THE MEDICARE+CHOICE PROGRAM AFTER ONE YEAR

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND ENVIRONMENT

OF THE

COMMITTEE ON COMMERCE
HOUSE OF REPRESENTATIVES

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THE MEDICARE+CHOICE PROGRAM AFTER ONE YEAR

FRIDAY, OCTOBER 2, 1998

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:08 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Hastert, Upton, Stearns, Burr, Bilbray, Ganske, Brown, Waxman, Pallone, Green, DeGette, Hall, Furse, and Dingell (ex officio).

Staff present: Howard Cohen, majority counsel; Eric Berger, professional staff; Robert Simison, legislative clerk; Bridgett Taylor, minority professional staff; and Amy Droskoski, minority professional staff.

Mr. BILIRAKIS. The hearing will come to order.

Last year in the Balanced Act, BBA 97, Congress created the Medicare+Choice Program to provide Medicare beneficiaries with a new array of choices of private health care plans. The goal of the program was to modernize the Medicare program by allowing Medicare to offer the same type of innovative plan options that now dominate the private health care marketplace.

Medicare beneficiaries could elect to obtain services through the traditional fee-for-service system, or elect one of the new Medicare+Choice options which are coordinated care plans; like HMO's, provider sponsored organizations, preferred provider organizations, medical savings accounts, and private fee-for-service plans.

The guiding principle of this new system was to allow the marketplace to create new private health care plan options and to provide beneficiaries with the information they need to make informed choices. For many elderly individuals, Medicare HMO's covered both their cost-sharing with the need to purchase expensive medigap insurance, while also providing them with extra benefits like coverage of pharmaceutical drugs.

In the past several years, the number of Medicare beneficiaries who enrolled in HMO's has grown substantially with approximately 6.5 million enrollees by 1997. With the establishment of the Medicare+Choice program and revisions in the payment method for plans, there was the expectation that enrollment in such plans would continue to accelerate.

Unfortunately, during the last several weeks, the exact opposite appears to be taking place. A significant number of health plans have terminated their contracts with Medicare. These risk plans covered approximately 300,000 beneficiaries. Although the vast majority of beneficiaries live in counties where other risk plans are available, this trend is certainly very deeply disturbing.

There are many factors which have led to the current situation. First, we in the Congress must acknowledge that the BBA substantially restructured the system for setting the rates by which Medicare pays health plans, while simultaneously cutting billions from the program. The BBA also established very aggressive timeframes to jump start the program.

Unfortunately, these ambitious deadlines may be having the opposite effect. For any change of this magnitude and complexity, it will take at least several years to solve the glitches which accompany such a significant restructuring.

HCFA has also fundamentally created many problems by issuing interim final regulations that contain overly expansive interpretations of the BBA and run counter to congressional intent. The regulations are guided by a rigid bureaucratic mentality which will lead to ossification rather than modernization of the Medicare program. These regulations have already led to less, rather than more, options and choices for Medicare beneficiaries.

So far, HCFA has demonstrated a fundamental misunderstanding of the goal and spirit of the Medicare+Choice program. This program will only succeed by HCFA's commitment to flexibility and innovation in regulation.

Finally, health plans must also be flexible in conforming to the new system. The new payment system, the requirement for the implementation of a risk adjuster, new patient protections with their emphasis on quality, and the user fee for providing information to beneficiaries were all essential elements of the BBA legislation.

In the next several weeks and months, it will be critically important for Congress, HCFA, private health plans and Medicare beneficiaries to work together in a cooperative manner to make the Medicare+Choice work. We all need to make this commitment today.

I would like to conclude by welcoming our first witness, Mike Hash, the Deputy HCFA Administrator. Mike provided distinguished service for this subcommittee for a number of years on the issues of Medicare and health care reform. Michael, after all the other opening statements, we will have you at the desk, but we do look forward to your testimony and know that your direct and knowledgeable approach to issues will help clarify the issues of this very complex program.

The Chair now recognizes the gentleman from Ohio, Mr. Brown, for an opening statement.

Mr. BROWN. Thank you, Mr. Chairman, for holding this hearing on Medicare+Choice. Last year, we enacted a number of changes in the Medicare program and today's hearing will focus on the new health plan choices for beneficiaries in Medicare and revisions in the way we pay plans.

I am interested to hear from both Mr. Hash, the Deputy Administrator of HCFA and the industry about the progress to date in

this area. One of the challenges we face in implementing these new choices is, as we move away from fee-for-service into managed care, it becomes more difficult to determine whether seniors are getting the care they need and whether taxpayers are getting what they pay for.

In fee-for-service, dissatisfied beneficiaries can vote with their feet and choose another doctor. In managed care, eventually they will be locked into a plan for at least a year. That's why Congress included in the Medicare+Choice statute provisions to allow HCFA to act as a more prudent purchaser, to require HCFA to protect beneficiaries, to require HCFA to get access to the kinds of data needed to determine whether or not both seniors and the government are getting value for their dollars.

In this regard, HCFA has an obligation to Congress, to taxpayers, to beneficiaries, and to health plans to make sure that this process works smoothly. I am glad to have the opportunity to hear both sides of the story today.

If plans are having difficulty complying with the requirements, we need to know why and what can be done about it. If the law reduced payments to plans too much, we need to know that. If HCFA has extended its reach beyond its authority, we need to know that, too.

However, I'd like to mention two issues of particular concern. First, I've heard warnings from plans only recently regarding HCFA's regulations. The interim final regulation on Medicare+Choice has been out since June. The guidance on the quality improvement systems in managed care has been out since January.

Yet it wasn't until September 16 that HCFA received word from the American Association of Health Plans about the impending "crisis" resulting from the Balanced Budget Act requirements. It is curious that the industry waited until this point to announce their inability to comply with basic quality standards and their inability to provide care under the average community rates that the plans themselves submitted to HCFA in May.

Further, part of what they are claiming to be the problem, the quality system, was announced in January, well before the rates were submitted in May. And finally, the quality requirements have been substantially relaxed since the January version was released.

Moreover, the Federal employee health plan rates were due in May, and health plans incorporated a 10.6 percent increase in health care costs in the coming year. Medicare and private sector cost increases tend to track each other closely.

What happened in Medicare? Did plans forget to take these factors into account when submitting rates for the Medicare program? Was it just now that plans are discovering that they need to make adjustments? Given the evidence plans had prior to submitting their ACR's, I'd like to know what happened.

I recognize this is the first year of implementation of the new Medicare+Choice program. In this transition year, there will be many changes for plans, HCFA and beneficiaries. We are creating a new system and implementing it at the same time. It will require extra effort from everyone involved to make sure this program runs smoothly.

My second, and larger, concern ultimately centers around potential cream skimming and ultimate privatization of Medicare. In too many cases, we are seeing the youngest and the healthiest, and in many cases, the most affluent, join private managed care plans, leaving in public fee-for-service Medicare, the most expensive patients to insure, to the point that private insurance insures people when they are well, and taxpayers insure people when they are sick.

If we allow that to happen in this inexorable way it seems to be happening, we will end up with two plans: one more private in nature of the most affluent, the healthiest and the youngest; and a second, that generally doesn't have the broad public support that Medicare has always had, of the oldest and the poorest and the sickest. And that's what we ultimately need to avoid in breaking up this system, Medicare, that has served the public so very well.

Mr. Chairman, I thank you for holding this hearing.

Mr. BILIRAKIS. I thank the gentleman. Mr. Hastert, for an opening statement.

Mr. HASTERT. Mr. Chairman, I thank you for holding this very important hearing. I am very concerned today that the intent of Medicare reform legislation is not being implemented. I am grateful for the opportunity this morning to investigate solutions to the Medicare implementing problem.

In our bipartisan Balanced Budget Act of 1997, we worked to establish a Medicare program that afforded beneficiaries access to affordable, effective choices in Medicare. We know that a one-size-fits-all approach to health care doesn't work. When we passed the BBA, we hoped to mimic the health care marketplace that currently offers folks outside of government health care programs a wide variety of options. We hoped to provide seniors with the ability to choose the Medicare option that best fits their needs.

Mr. Chairman, my Medicare constituents informed me loud and clear last year that they wanted more choices in Medicare. Through a strange set of circumstances, we had a situation in the Fox Valley of Illinois that left Medicare beneficiaries without a managed care option.

A widely popular managed care entity decided to go out of the Medicare business. You would not believe how outraged these Medicare beneficiaries became. The 1,100 seniors who were impacted, my office held an information forum and over 600 seniors showed up. They were very angry that managed care was no longer a choice for them.

Even though they still had access to the traditional Medicare program, they wanted the option of joining a Medicare managed care organization. It was a truly enlightening experience for me, Mr. Chairman. Despite all the backlash against managed care this year, my constituents told me loud and clear that they wanted the options.

Now, for a variety of reasons that we may explore today, my constituents are again going to be lacking choice where it is sorely needed. I was informed yesterday that a Medicare managed care plan will be dropping out of the Medicare program in two counties in my area. Illinois is not the only area with this problem.

Apparently, many managed care companies have announced that they can no longer participate in Medicare, and this deeply concerns me. The intent of the Balanced Budget Act was simple: provide effective choice. And I am eager to hear your thoughts on what we must do to ensure that the Medicare+Choice program is a success.

I recently wrote a letter to the Health Care Financing Administration, which is represented here today, and I asked them to immediately reevaluate their so-called megareg to implement the BBA. They should do all they can to immediately lift excessive and burdensome regulatory and administrative requirements on health plans and promote choice. They also ought to engage in a serious dialog with the health plans to see what can be done to encourage more choice and participation.

I would like to learn more about the argument that payment rates are too low to sustain Medicare participation. In my district, the two counties where the health plan is pulling out actually have comparatively high reimbursement rates.

I would like to hear more about the administration's decision to implement additional and discretionary requirements on health plans through the Patient's Bill of Rights and regulation outside the scope of the BBA.

I look forward to the testimony of our panelists and hope we can immediately begin to solve this very, very serious problem. Thank you, Mr. Chairman, for having this hearing.

Mr. BILIRAKIS. I thank the gentleman. The gentleman from Michigan, Mr. Dingell, for an opening statement.

Mr. DINGELL. Thank you, Mr. Chairman. First of all, I commend you for holding this hearing. In the Balanced Budget Act of 1997, the Congress created a new program called Medicare+Choice, which substantially expands options for beneficiaries.

On June 26, 1998, the Secretary of Health and Human Services issued regulations implementing the Medicare+Choice program. We have given the Secretary and the Health Care Financing Administration a tremendous challenge. So your supervision at this time is going to afford us an opportunity to assure that that challenge is met properly.

The new choices for the Medicare program will work only if the health care industry, the seniors, and all others choose to participate in the new plans created under the Medicare+Choice proposal in a proper fashion.

More importantly, however, it will only be successful if the seniors get high quality health care, which they deserve, and upon which they have come to depend.

Fortunately, the Congress has insured that seniors are protected by allowing them to stay in the traditional fee-for-service program upon which they have relied for better than 30 years, thus maintaining the commitment of this Nation to our senior citizens during an implementation period fraught with serious uncertainties.

I am pleased that we will hear today from Bruce Bradley, Director of Managed Care Plans for General Motors. Mr. Bradley has been an important leader in the health care quality community and recognizes that both corporate and public purchasers must assume

a leadership role in driving quality improvement in our Nation's health care system.

Purchasers must demand performance measurements on quality and work with providers to identify and to implement opportunities for improvement. General Motors and the other automobile companies have provided great leadership in terms of both performance measurements on quality and other questions associated with health care. And he can bring a valuable view on this matter to the committee.

If Medicare is to become a prudent purchaser like GM, it must demand that plans meet appropriate quality standards. And you and I on this committee will be judged by how we do in seeing to it that that goal is implemented.

I would also like to acknowledge and welcome Mr. Michael Hash, Deputy Administrator from the Health Care Financing Administration, to our committee. Mr. Hash was a respected committee staff member for 5 years, and we are pleased to see that he has brought forward his talents to the implementation of this program. I look forward to hearing from both Mr. Hash and Mr. Bradley and the other witnesses today.

Again, Mr. Chairman, I thank you for holding this hearing. I commend you. We have much to do here and much to learn and a great opportunity, as well as substantial risk. Thank you.

[The prepared statement of Hon. John D. Dingell follows:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, thank you for holding this hearing. In the Balanced Budget Act of 1997, Congress created a new program called Medicare+Choice, which substantially expands options for beneficiaries. On June 26, 1998, the Secretary of Health and Human Services issued regulations implementing the Medicare+Choice program. We have given the Secretary and the Health Care Financing Administration a tremendous challenge.

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I would also like to acknowledge and welcome Mr. Michael Hash, Deputy Administrator from the Health Care Financing Administration to our committee. Mr. Hash was a respected subcommittee staff member for 5 years and we are pleased to see that he has brought his talents to the implementation of this program. I look forward to hearing from both Mr. Hash and Mr. Bradley and the other witnesses here today.

Thank you again, Mr. Chairman for holding this hearing.

Mr. HASTERT [presiding]. The gentleman's time has expired. The gentleman from Florida.

Mr. STEARNS. Good morning, and thank you, Mr. Chairman. I looked at my statement, and I'd like to read a portion of it. But I'd

like to start off with I just can't tell you how many faxes and letters and e-mails I have received from my constituents asking me these questions: Why don't all counties in my district receive the same rate of payment? Why do HMO's charge certain areas nothing in premiums and others charge upward of $50 or $60?

When our staff tries to explain it to them, they don't seem to understand or they just don't agree with us. And this creates an angry constituent. And they are vocal in North Florida, which is my district, and it's rural, but also includes Western Jacksonville.

So I am glad that you are holding this hearing today. We made a commitment when we passed the Medicare+Choice program, and so I am anxious to see how it works out.

The Medicare Board of Trustees urged Congress to take action designed to control the hospital insurance program and to address the projected financial imbalance in both the short range and the long range solvency of the program through specific legislation. The Trustees believed that prompt, effective, and decisive action was necessary.

Of course, Mr. Chairman, we responded to that with the Medicare+Choice program. The focus of today's hearing is to look at this program in its main existence. But so far, Mr. Chairman, or not so good, maybe—at least that's what I'm hearing from the seniors in my district about this program. I think we all recognize that any new program is going to have to have its share of growing pains, and Medicare+Choice is no different from other programs in that respect.

As I mentioned earlier, my area is largely rural, and it has a huge seniors population, so these two factors do not necessarily make it very attractive to HMO's looking for new markets. In fact, I regret to report that instead of attracting new HMO contracts into my area, we are losing those that already operate in my district. And I find this very troubling and I am hopeful that when this new program is fully implemented, that the problems we have already encountered will be resolved.

This is a vast, complicated program to begin with, and perhaps many in Congress have seen the consumer magazines that have come out with explanations of the Medicare+Choice program. It's complicated, it's formidable, and a lot of seniors are saying they just don't understand it.

So for that reason, Mr. Chairman, I think this hearing is very timely. And with your allowance, I would like to make my entire statement a part of the record, with unanimous consent.

Mr. HASTERT. Without objection. The gentleman's time has expired.

[The prepared statement of Hon. Cliff Stearns follows:]

PREPARED STATEMENT OF HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Thank you, Chairman Bilirakis, for holding this timely and important hearing today on the Medicare+Choice Program After One Year. Like you, I have a large seniors population and they rely on their Medicare benefits to cover their health care needs.

Last year we made a commitment—that commitment was to save Medicare from bankruptcy. The task of this Committee was to transform the current Medicare program into a viable and self-sustaining system. The need to do something was promulgated by the looming financial crisis in the program.

The Medicare Board of Trustees urged Congress to take action designed to control the hospital insurance program and to address the projected financial imbalance in both the short range and the long range solvency of the program through specific legislation as part of broad-based health care reform. The trustees believed that prompt, effective, and decisive action was necessary.

We responded to the Trustees call to action by passage of the Medicare+Choice program. What this proposal does is move Medicare from a one-size-fits-all warehouse plan to a supermarket of choices—including private sector options.

As you know, under this proposal, traditional Medicare continues to exist, but seniors may also choose from new health-care options such as HMOs, or PPOs that are provided to all other Americans. These plans cost less than traditional Medicare because they are managed more efficiently. That's where the savings come from.

These plans also provide benefits not available in traditional Medicare, such as prescription drugs, preventive care and eyeglasses. Many of these plans also eliminate the need to purchase a Medi-Gap policy, so seniors can have all their healthcare needs taken care of by one plan.

The focus of today's hearing is to look at the new Medicare after its first year in existence. Mr. Chairman, so far, not so good, or at least that's what I'm hearing from the seniors in my district. I think we all recognize that any new program is going to have its share of growing pains and Medicare+Choice is no different from other programs in that respect.

The Sixth District of Florida has, as I have previously indicated, a huge seniors population. It is also a largely rural area. These two factors do not make this attractive to HMOs looking for a new market. In fact, I regret to report that instead of attracting new HMO contracts into my area, we are losing those that already operate in my district. I find this troubling and I am hopeful that when this new program is fully implemented that the problems we have already encountered will be resolved.

However, from what I am hearing it does not sound like the prognosis is a good one. Why am I so skeptical? There are inherent problems that have already surfaced including requiring each Medicare+Choice group to submit specific information about premiums, cost sharing, and additional benefits by May 1 of each year. Why is that a problem? Because these plans were required to submit information based on regulations that were not issued until mid-June of this year. That is something that could create a whole new set of problems in 1999.

Medicare is a vast complicated program to begin with and the changes that will occur over the next few years are bound to compound the frustration and fear seniors already feel about this program. I do anticipate that we will be made aware in very short order what seniors don't like about Medicare+Choice.

I would like to talk about the two specific areas in the program that we hear about the most from my constituents—home health care and the discrepancies in premiums and the differential in payment rates in counties within in the same geographic region.

Mr. Chairman, I think we all recognize that home health care is vital to many of our Medicare recipients and nobody wants to see our seniors suffer needlessly. We all remember the many witnesses who testified about home health care organizations that had bilked the Medicare program out of billions of dollars. Our intention was to reduce unnecessary and fraudulent spending in home health. I believe we were right in setting out to rid the Medicare program of fly by night organizations that cost the program money that could have been spent on taking care of the needs of seniors.

However, the Interim Payment System now in place is a disaster for rural areas and must be corrected. I support implementing a new IPS blend that is more equitable than the present system. Furthermore, new agencies must not be penalized and should receive treatment similar to that of existing agencies. It is my understanding that we may be on the verge of finding a compromise. That is good news. I would support such legislation.

Mr. Chairman, I can't tell you how many letters, faxes and E-mails I receive from my constituents asking me the following question: Why don't all counties receive the same rate of payment and why do HMOs charge certain areas nothing in premiums and others charge upward of fifty and sixty dollars. When we explain to them the reasons why, they either don't understand or just don't agree with this. They believe it is discrimination and they are very angry.

My constituents are very vocal about what they expect—they are equally as vocal about what they say we promised them. I am sure that my colleagues here today have heard similar complaints from their people back home.

I hope that we are able through the education campaign that HCFA will be undertaking to reassure Medicare recipients across the country that we have their best

interest at heart. The bottom line is that the Medicare Board of Trustees made compelling arguments to Congress about the need to reform the program if we hoped to see it available for future generations. I think we can achieve our goals. Obviously, it won't be easy but working together we will face each obstacle as it occurs and find solutions to problems as they present themselves.

I look forward to hearing from our distinguished witnesses and learning from them how they view the progress that has been made thus far and what, if any shortfalls they foresee with the regulations that have been developed. Thank you, Mr. Chairman.

Mr. HASTERT. I'd like to recognize the distinguished gentleman from California, Mr. Waxman.

Mr. WAXMAN. Thank you very much, Mr. Chairman. I am pleased that we are having this hearing today to examine the progress and the problems of the Medicare+Choice program 1 year after its enactment. We are about to embark on a substantial change in Medicare that provides some very promising opportunities for Medicare beneficiaries. But these changes also have the potential to cause a great deal of confusion, risks, and problems for the Medicare population.

It is in all of our interests to have this program operate as smoothly and effectively as possible. HCFA, the industry, and the Congress all share that goal, just as they share the responsibility for making it work. It is unfortunate, though, that just as we are about to embark on these changes which were designed to offer more choices and more managed care options to these Medicare beneficiaries, we are faced with the reports of HMO's that had been participating in Medicare on a risk basis now withdrawing from the program.

Chairman Bilirakis indicated that is happening in his district, and indeed, it is also happening in my own district, where Prudential is terminating its contract with Medicare. My first thought on seeing these HMO's withdraw from the program was a simple one. Thank goodness that we have a fee-for-service Medicare. Thank goodness that we can be sure that these beneficiaries have somewhere to go. If there ever was an early warning that we'd better be sure to keep traditional Medicare as a viable option, this is it.

Now I know we are going to hear a lot today about why this is happening. The Balanced Budget Act changes in payment, the need to file reports on projected costs at an early date, the increase in health care costs, and the regulatory requirements of the Health Care Financing Administration are among them.

But rather than try to point the finger one place or another, I think we should all realize that some of this is happening because of the timetable we in the Congress imposed when the Balanced Budget Act was adopted. We wanted this program underway quickly; we wanted to make lots of information available to beneficiaries, so they could make informed choices.

We wanted to make sure that quality of care and patients' rights were protected. And yes, we also wanted to adjust payment rates so that we could achieve savings in Medicare. And we wanted to do all this under very severe time constraints. It looks to me like the industry has had just as much difficulty meeting the time schedule as HCFA has had.

So I hope this hearing won't be just trying to say HCFA is to blame or the industry is to blame. If everyone is struggling, maybe

we in the Congress also have to accept some of the responsibility for the difficulties we are incurring.

And we all have to ask how we can work together to make whatever changes are necessary to make this program work the way we hoped and intended. By that, I don't mean changes that are rushed through and ill-considered, that only add to the confusion facing beneficiaries this year and result in fewer benefits and higher premiums for them, because none of us should lose sight of who we are trying to serve here, the Medicare beneficiaries.

They are not here to testify today, and we are not going to hear what they think. But in the end, it is their interests that we ought to realize are paramount. I look forward to hearing from the witnesses that are here today.

Let me just note that I am especially pleased to have Mike Hash, who is here for his inaugural appearance before the subcommittee. He is doing a great job over at HCFA, and he did a great job for us when he served as a member of our staff with his expertise on Medicare. I know he will continue that tradition today from the other side of the table.

Mr. Chairman, I would like to ask to put in the record, what I think is a terrific article by Jane Bryant Quinn in Newsweek that outlines the problems that we are facing with this Medicare+Choice program. I think it's informative.

Mr. HASTERT. Without objection, so ordered.

[The article follows:]

[September 28, 1998—Newsweek]

REINVENTING MEDICARE

By Jane Bryant Quinn

In November, Medicare takes the first step toward what will be a historic change, and tens of thousands of older people won't know what hit them. New types of senior health plans are on the drawing board. The government is bracing for a tsunami of anxious telephone calls—and so, for that matter, should seniors, adult children, community groups and corporations that offer retiree health plans.

Two misunderstandings have emerged already, so before I go any further let me clear them up. First, basic Medicare benefits have not been cut. You'll simply be offered new ways of managing your care. Second, you are not required to choose a new plan. Do nothing, and you'll keep the Medicare coverage you already have.

At present, Medicare is delivered in one of two ways. The most popular is the traditional fee-for-service plan, now called Original Medicare. You can see any doctor—internist or specialist—who'll accept you as a patient. The government covers most of the cost. As a backup, seniors typically buy private medigap insurance, which helps pay the bills that Medicare doesn't.

Alternatively, you might join a Medicare HMO. There, you're under the care of a single, "primary" doctor, who decides on the medical treatment you'll get. HMOs offer broad enough benefits that you don't have to bother with private medigap.

Seniors have always seemed happy enough with these two options. But our lawmakers had bigger ideas. Last summer, they authorized four new kinds of senior health plans, to privatize the program, add high-income options and lengthen the reach of managed care. They dubbed the collection Medicare+Choice.

Stir up: Only two of the plans are apt to stir any interest in the public at large. With a "preferred-provider organization" (PPO), there's more freedom of medical choice than HMOs provide. You can usually opt to see any doctor within the network, any time, including specialists. Another entry is the "provider-sponsored organization" (PSO), an HMO run by doctors and hospitals rather than an insurance company. PSOs say they'll be more patient-friendly. Neither of these plans can charge you extra fees.

Your other two choices are government-subsidized private insurance. One of the plans—private fee-for-service—works like Original Medicare but can charge you more. It could attract the fancy doctors who won't work for normal Medicare fees.

Or you might try a Medicare Medical Savings Account (MMSA). Here, the government buys you a private health-insurance policy with a high, upfront deductible. It also makes annual contributions into your MMSA. You have to pay your own medical bills, up to the deductible (either out-of-pocket or with funds from your MMSA). After that, your insurance kicks in. Both plans let doctors and hospitals charge you a gold-plated price. If Medicare were a cruise ship, these would be the luxury suites.

No matter which plan you choose, you pay the normal premium for Medicare Part B (which covers doctor bills). Some of the plans charge additional monthly fees.

Congress set a November deadline, for dumping the news about Choice plans on Medicare's 38 million enrollees. But time and money were too short. The Health Care Financing Administration (HCFA), which manages the program, scaled back.

Guinea pigs: Instead, Medicare+Choice will start with 5.5 million designated guinea pigs—namely, the Medicare enrollees in Arizona, Florida, Ohio, Oregon and Washington State. They'll get a handbook called "Medicare & You," which explains the new plans and offers a worksheet for comparing them. It also lists the plans you can join, with each one's basic rules and costs. As backup, there's an 800 number, a Web site (www.medicare.gov) and local sources of expertise.

In the other 45 states, Medicare people will get a bulletin this year, mentioning Medicare+Choice in brief. Local plans won't be listed, but they're on the Web site. If you're not on the Web, call your library or a senior-citizen group. In November 1999, Medicare+Choice will go nationwide.

Luckily for HCFA, as well as for the guinea pigs, hardly any new-style plans have been organized so far. For the trial run, your only choices will be Original Medicare or an HMO. The first PSO, from St. Joseph Healthcare in Albuquerque, N.M., may be ready in January. No Medicare MSAs or private fee plans have yet run up a flag.

As they start, however, they'll be soliciting you, by phone and mail. Right from the get-go, you'll need to understand the risks:

If you leave Original Medicare for one of the Choice plans, you'll no longer need Medigap insurance. But what if you come to hate your new plan? Original Medicare will take you back. But you're guaranteed a return to Medigap only if this is the first time you've changed your mind, and providing that you quit the Choice plan within the first 12 months. Otherwise, you're out of luck.

Choice plans aren't sure things. Sometimes they'll fail. Sometimes they'll drop all their Medicare patients in areas where they're unprofitable (several HMOs have gone this route). If you're dropped, you automatically return to original Medicare. But to be sure of reclaiming a Medigap policy, you have to apply within 63 days—and how many seniors will know that?

You may be tempted to leave a retiree health plan because, for you, a Choice plan looks cheaper. But company plans may offer better benefits—for example, in prescription drugs. "Employers are trying to figure out how to tell people not to make rash decisions," says consultant Chip Kerby of William M. Mercer, Inc.

By law, HMOs are supposed to cover most of the cost of teaching seniors about Medicare+Choice. (And why not? The handbook advertises HMO services.) They're resisting the money bite scheduled for 1999, but frankly, it's too late to squabble. Big changes require big campaigns. Booklets and 800 numbers won't do it, says Ron Pollack, head of Families USA in Washington, D.C. Seniors need counselors they can talk with face to face.

Older people weren't demanding Medicare options. Congress dreamed them up, and owes you a total-immersion course on how to choose. Until then, be smart. Keep the Medicare plan you have.

Mr. WAXMAN. I yield back the balance of my time.

Mr. HASTERT. The gentleman.

Mr. BROWN. Mr. Chairman, I ask unanimous consent to enter everyone's opening statement into the record from both sides.

Mr. HASTERT. Without objection, so ordered. The gentleman from Ohio, Mr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman. I was a little bit west of Ohio, Mr. Chairman. Anyway, thank you, Mr. Chairman. I applaud you for calling this hearing today, and I look forward to the testimony.

It is appropriate that we take this opportunity to give the Medicare+Choice program its 1-year checkup. Sadly, it is clear that the patient is not as healthy as we might have hoped. The promise of new options has yet to be met. Few PPO's and PSO's appear

poised to enter the market. And I have been told that not a single MSA will be sold to a Medicare beneficiary next year.

Late last month, news reports indicated that the Medicare HMO's were appealing to HCFA to revise their calculations to increase premiums or decrease benefits for enrollees. Like other Members of Congress, I contacted HCFA Administrator Nancy-Ann Min DeParle to express my concern.

The Balanced Budget Act contained a statutory deadline for plans to file their rate estimates for the coming year, just as plans serving Federal employees currently do. I was very pleased to learn that Administrator DeParle had turned down that request, and I am very supportive of her decision.

The statutory deadline gives the already overburdened agency a chance to develop comparative information for seniors to explain their options. Allowing a last minute adjustment by the health plans would impose unrealistic demands on HCFA.

As time permits, however, I think HCFA might consider reviewing the way HMO's set their rates and how their payments are calculated. In particular, the agency may find that significant program expenditures have been lost because Medicare risk plans have been overpaid.

A proper review might consider ways to correct this in the future and to determine whether any of these losses can be recouped. I hope to further explore these and other issues with the witnesses here today, and I yield back the balance of my time.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Pallone, for an opening statement.

Mr. PALLONE. Thank you, Mr. Chairman, for having this hearing, because I think it is very important. I have had a number of forums and outreach programs with seniors in my district over the last couple of months, and I have to say they are very nervous about the changes in the Medicare program and also the array of choices that they have or will soon be facing.

First and foremost, I think we have to do a better job in making sure all seniors understand that no matter what happens, they will not lose their Medicare. A great many seniors do not understand that no matter what happens, they will not lose their Medicare. A great many seniors do not understand that no matter what happens, they will still have their traditional fee-for-service program to fall back on.

I have also found that many seniors do not know what their options are if the plan they are enrolled in leaves the market. Enrollment in Medicare HMO's is on the rise because many seniors find the benefits such plans offer to be superior to the traditional fee-for-service program. But those who choose the HMO's may find themselves in a very precarious position if their plan leaves and they don't have the option to enroll themselves in a similar plan.

Some may find that there is no plan at all in the area and may be left only with a fee-for-service option, which then raises concerns about the availability and affordability of medigap policies. There are a lot of pitfalls out there, and while that is understandable because the education campaign is still in its infancy, I hope we will

spend a good deal of time talking about what types of information disclosure requirements the plans will be required to follow.

Specifically, I would like to discuss what types of information a plan must disclose when it pulls out of a market and what are its obligations to the enrollees. I also want to examine what is being done to make sure seniors understand that the benefits that are the most attractive to them are also the ones that oftentimes are not guaranteed from 1 year to the next.

In addition to examining the type of information that is being provided to beneficiaries when their plan leaves the market, we need to have a thorough discussion about why risk plans are leaving the market in the first place.

And this is a very alarming trend. Just yesterday, United Healthcare announced its decision not to renew Medicare risk contracts in seven counties in New Jersey, including the two counties that I represent, Monmouth and Middlesex Counties. And according to United, this decision is going to affect about 2,500 New Jerseyans.

In a letter to my office announcing this decision, United stated, and I quote, "that new Federal requirements emerging from last year's Balanced Budget Agreement have created significant operational challenges in a number of markets." And according to United, the 2 percent payment update factor, coupled with the inability to implement the blended payment rate in certain areas, has held payments far below medical cost trends.

United also claims that user fee assessments, quality reporting requirements, and new provider contracting requirements place an administrative burden on health plans that not only adds considerable expense, but diverts resources from coverage of medical care.

Now, I use that as an example because it's in my own district, but of course, it comes as no surprise to me or the members of this committee that many plans are not happy with the new payments and requirements, and there is some evidence that plans are being overpaid. I'm sure it is also true that a good many will not get involved if they cannot afford a good plan for the cost.

Whatever the reasons, we need to get to the bottom of them and address. And I think this subcommittee needs to take a good hard look at what type of impact the cost of prescription drugs is having on these decisions to leave and stay out of the market, and of course, the effect on seniors.

Last, Mr. Chairman, I am looking forward to finally having the opportunity to discuss quality standards. As we all know by now, many people in the industry, including some who are before us today, oppose a good number of patient protections that a lot of members on this committee and in this Congress would like to see afforded to all patients in this country.

And while I know that most of these protections are already part of Medicare, I understand some of that contentiousness has spilled over into the proposed quality standards for Medicare+Choice. And with regard to HCFA's release of this revised version of the quality and proven standards for managed care regulations, I look forward, as some of the others have said today, to hearing the perspectives of our witnesses on the revised draft and hope that we can reach

a consensus on what needs to be done to ensure that Medicare beneficiaries receive the best possible care.

Again, I want to thank you, because I think that we need hearings like this. Even though it's the last week or so, it is important that we have this before we adjourn. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Bilbray.

Mr. BILBRAY. Mr. Chairman, I will ask for unanimous consent to enter my statement into the record.

Mr. BILIRAKIS. Without objection, the opening statements of all members of the subcommittee will be put in the record.

Mr. BILBRAY. I'd just like to put an addendum on this that I find that though the concerns seem universal from region to region across this country, I suspect that the reason for the concerns are not universal. I think that's what we have to be willing to look at and get in depth about, that it's not a universal problem. It may be a universal concern, but the problems that are generating those concerns may be as unique as the regions of this Nation.

I yield back, Mr. Chairman.

[The prepared statement of Hon. Brian P. Bilbray follows:]

PREPARED STATEMENT OF HON. BRIAN P. BILBRAY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, thank you for conducting this hearing today on the Medicare+Choice program after one year. I look forward to hearing the testimony this morning from HCFA and the various health plans represented before us.

I have several concerns about the implementation of Medicare+Choice. For instance, I have at least one Medicare risk plan that has pulled out of the market in my district. I expect that more will follow suit. We should all be concerned about this as it leaves Medicare beneficiaries with fewer choices and undermines the market.

We should also be concerned about the reasons why some of these plans are dropping out. In my district, with its heavy saturation of managed care plans, the reason is inevitably the payment rate. In other parts of the country, the reasons might be varied, but I think we need to seriously look at the adverse effects that the payment rates are having on some Medicare risk plans.

Another concern I have is the ambiguity of HCFA's Medicare+Choice Regulation in terms of how long a plan must stay out of the market if they drop out of the Medicare program. There is sufficient confusion as to the approaching expiration of the 1876 law and whether plans have to wait the full five years before they can reenter the Medicare program.

Finally, we should be concerned about the effect of these problems on Medicare beneficiaries. Will seniors be faced with fewer choices, less benefits, and higher premiums? This was truly not the intent of the Medicare+Choice program when Congress was considering it during the budget reconciliation last year.

I look forward to hearing the testimony of the witnesses this morning, and am hopeful that some of these concerns can be addressed. Once again, Mr. Chairman, thank you for holding this timely and important hearing, I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. Ms. Furse, for an opening statement.

Ms. FURSE. Well, Mr. Chairman, I have a brilliant 5-minute statement, but because I know that you would like to move this hearing on, I will ask just to have it introduced in the record. Thank you.

Mr. BILIRAKIS. I thank the gentlelady for her consideration.

Mr. Upton.

Mr. UPTON. Thank you, Mr. Chairman. I just have a brief statement. I have had a number of meetings over the last couple of months with constituents in my district and providers, as well, to

talk about the changes in Medicare. What is particularly alarming to me is the fact that my major providers are not likely to participate because the AAPCC rates are just frankly too low, and they know they are not going to be able to compete, which denies a lot of folks in Michigan from having that as an alternative.

The sense that I receive from literally hundreds of folks that came to a couple of the meetings that I had during the August break was very positive about the choices that they'd be able to have, the ability always to fall back into the traditional fee-for-service without any diminution of benefits. But in fact, if there's no reward for providers to be involved with PSO's or HMO's or whatever, the choices for my constituents become very limited and very sad.

I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. Ms. DeGette.

Ms. DEGETTE. Mr. Chairman, I also have a brilliant 5-minute statement which I'd like unanimous consent to submit for the record.

Mr. BILIRAKIS. Without objection. Thank you.

[The prepared statement of Hon. Diana DeGette follows:]

PREPARED STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Good Morning. I will be brief as I know we have a long list of very capable witnesses to hear from today.

I would like to mention my hope that this committee and that our witnesses use the opportunity Chairman Bilirakis has given us today to constructively evaluate the implementation of the Medicare+Choice program. We must not forget that the changes we made to the Medicare program last year were significant and were bound to trigger growing pains when they were implemented. Because of the strict timelines Congress mandated HCFA to follow, it is no surprise that the industry is feeling a little heartburn.

Nonetheless, I am very concerned by the news that a number of managed care plans have said it is fiscally impossible for them to continue contracting with Medicare because of HCFA's regulations. The first and foremost responsibility of the Commerce Committee is to ensure that with the Medicare+Choice program, beneficiaries have expanded choices with adequate quality and access protections. If we fail to meet that goal, the improvements we thought we made to the Medicare program last year will not be worth the paper they were drafted upon. Therefore,

Finally, I hope that as we evaluate the current status of the Medicare+Choice program, we think beyond just HCFA regulation and carefully consider today's marketplace and the role of managed care in delivering services to beneficiaries. If we do not look at the success or shortcomings of the Medicare+Choice program through this lense, we will simply be enacting policy in a vacumn.

I want to thank the Chairman for inviting such a balanced and distinguished panel of guests. I look forward to a solution-oriented discussion today. Thank you and I yield back the balance of my time.

Mr. BILIRAKIS. Mr. Green, opening statement.

Mr. GREEN. Thank you, Mr. Chairman. I will just take a few minutes and submit my full statement for the record. But this morning in the Houston Chronicle we have an article, "HMO's to Drop Tens of Thousands," and in light of recent events and more managed plans are pulling out of Medicare, I hope today's hearing will shed light on not only what is right, but also what is wrong with Medicare+Choice.

Today, over 300,000 senior citizens have been dropped by their Medicare+Choice managed care plans, and nearly 30,000 of those live in areas that are not served by other coordinated plans, essentially, taking the Plus Choice out of Medicare.

My concern is a lot of our seniors became dependent on managed care for prescription medication supplements and that is the concern now, to literally have the rug pulled out from under them. Thank goodness, the Balanced Budget Amendment also included the provision, Mr. Chairman, that they could go back for fee-for-service without being penalized for their supplemental. But again, that's still increased cost out of their pocket, with the increased cost of supplementals.

But I think this committee might look, before we experiment with Medicare in the future, that we make sure we have some programs that will be there year in and year out, and not subject to short-term profit motives.

[The prepared statement of Hon. Gene Green follows:]

PREPARED STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

I want to thank Chairman Bilirakis for scheduling today's timely hearing. In light of the recent events—that is more managed care plans pulling out of Medicare—I hope today's hearing will shed some light on not only what is right, but what is wrong with the Medicare+Choice program.

Today, almost 300,000 senior citizens have been dropped by their Medicare+Choice managed care plan.

Nearly 30,000 of these seniors live in areas that are not served by other coordinated plans—essentially taking the "plus choice" out of Medicare.

Even those who do have other options are terribly inconvenienced when they are forced to enroll in a new plan. Different coverages to learn, different policies to learn, and worst of all, different providers to get to know.

For a Committee that has spent so much time talking about the importance of continuity of care—it seems we have a lot of work to do.

We need to look at why so many managed care plans are pulling out of Medicare.

Is it because reimbursement rates are too low to make a profit—or that profits are just lower than they were before the BBA?

Is it the older plans who have been risk contractors with Medicare for years that are leaving? Or is it new providers who tried to jump in and make a quick buck?

On the flip side, I want to mention that I believe the Medicare+Choice program is working well for the overwhelming majority of the millions of beneficiaries it serves.

Because Medicare recipients benefit from the strong consumer protections in the Patient's Bill of Rights, we now have a model of how coordinated care can be appropriately delivered.

I hope this Subcommittee continues to work with our distinguished witnesses from the public and private sector who are here today to make the necessary and appropriate improvements so that Medicare+Choice can work for all Medicare beneficiaries.

Mr. BILIRAKIS. I thank the gentleman.

I believe that takes care of all the opening statements.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. RICK LAZIO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Thank you, Mr. Chairman. The timing of this hearing could not come at a more appropriate time. This hearing will hopefully resolve many of the concerns that we, as Members of Congress, have about the implementation of this program. Most importantly, I hope that our panelists will help us to guide our seniors through the maze that they will have to go through beginning January 1, 1999, when this new program takes effect.

This new program will let a wide variety of private sector health plans serve senior citizens for the first time. Unfortunately, those who choose to join may not know what they are getting into.

When we enacted the BBA, we implemented this new Medicare option in the hopes of saving money while, at the same time, ensuring that our seniors continue

to receive the quality health care they have been receiving under the current Medicare program.

However, we have much more work ahead of us. In New York, Medicare carriers have several concerns regarding the so-called "mega-reg" that could potentially inhibit innovation, lessen choice, limit provider participation which limits access to services. Carriers in New York also have expressed concerns to me regarding the uncertainty and confusion of many, many other elements of the regulation.

In light of this confusion, HMOs are fearful to participate in the program in the first place. Many have already declined to participate in this program at all. Many of these are some of the nation's largest managed care providers. Others are the only provider to seniors in rural and underserved areas—leaving many seniors without choice.

Officials have predicted that by 2005, 30 percent of Medicare's 38 million beneficiaries will enroll. If the program is successful, I would like to see as many as possible taking advantage of all the opportunities available under the Medicare+choice. However, a test given to senior citizens by the American Association of Retired Persons—AARP—found that only 1 in 10 understood the difference between traditional Medicare and Medicare+.

Our goal for the program is to give seniors more options without having to purchase costly Medigap insurance plans. This would save our seniors money by not having to pay for the costly premiums associated with Medigap and save the government money as well. However, if we do not resolve many of the concerns that our Medicare HMO carriers have, our seniors will have no option but to remain in the same plan they currently are in.

We must develop this system to be one that is easy to navigate—for the managed care provider—but also for the senior who must make some important decisions about his or her health care.

Mr. Chairman, thank you for calling this hearing to address the Medicare+Choice plan. Our seniors deserve to have these questions answered and I hope that this hearing will address all of these concerns.

Thank you.

PREPARED STATEMENT OF HON. BARBARA CUBIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WYOMING

Thank you, Mr. Chairman, for holding this important hearing which will allow us to hear how the Medicare portion of the Balanced Budget Act of 1997 is being implemented.

As I read the testimony from the witnesses, I could see a clear pattern developing. There is a general feeling that the Health Care Financing Administration's (HCFAs) regulatory changes have placed some severe burdens on how health care services are being provided to seniors.

Many of these regulatory burdens have nothing to do with delivering necessary medical services. Many of them have to do with administrative aspects of the law.

Mr. Chairman, I am a cosponsor of a House resolution that, in part, requests that HCFA streamline its guidelines for physicians who submit claims to Medicare for office visits and for other evaluation and management services.

The burdens that these types of administrative requirements place on doctors truly affects the quality of care they provide. As a former office manager for my husband's medical practice, I know the complexities that accompany submitting Medicare claims. We should not burden our health care providers with complex and sometimes duplicative paperwork requirements—their work is hard enough already.

If there are provisions of the Balanced Budget Act of 1997 that aren't working, we must address them. If there are problems with how the formulas established in the BBA pay for certain services, we must reevaluate them. If there is a situation in which HCFA can't do something that they are obligated to do by law, they must tell us so we can work out a solution.

These aren't insurmountable problems. If we work together and find common sense solutions we can ensure that seniors will continue to have quality health care and that providers will continue to stay in business to furnish health care.

However, it seems as if HCFA is not putting forth a good faith effort in issuing the new Medicare "Mega-Regulations." The June 26 rules seem to exceed the statutory language in the BBA. I'm sure the Administrator of HCFA would agree that the regulations must adhere to Congress's intent.

The most important thing now, as we move through this transitional period, is that we continue to provide quality care and a choice of quality care to as many Medicare beneficiaries as possible. We owe that to our seniors.

It is my hope that this hearing will allow us to learn the problems with the BBA and how those problems can be addressed in a bipartisan and fair manner.

Again, Mr. Chairman, thank you for holding this important hearing.

PREPARED STATEMENT OF HON. TOM BLILEY, CHAIRMAN, COMMITTEE ON COMMERCE

Thank you, Mr. Chairman.

I am pleased that the Health and Environment Subcommittee is holding this hearing today. The Medicare+Choice program stands as one of this Congress' most significant achievements.

Prior to the Balanced Budget Act of 1997, America's seniors were faced with an ailing Medicare program. Just as troubling, Medicare was a program that offered its beneficiaries little freedom to obtain truly responsive and effective coverage.

The Medicare+Choice program changed all that. The explicit intent of this program is to give seniors access to more choices than ever before, so that they can get better coverage than ever before.

That is why I am troubled by recent reports that this law—and the so-called "mega-reg" that HCFA has created to implement it—may in fact be reducing the choices available to America's seniors.

As we will hear today, early efforts by HCFA to write Medicare+Choice regulations have been widely viewed as too onerous and prescriptive. And a growing number of insurance providers are dropping out of the market.

I am pleased that the Agency is taking steps to rewrite portions of these regulations. And I would encourage them to continue doing so.

This Committee has always taken a dim view of regulations that exceed their statutory basis. That is why this is only the first of what I hope will be a series of formal inquiries by this Committee into this important program.

Again, Mr. Chairman, thank you for convening this hearing today.

Mr. BILIRAKIS. The Chair now calls the first panelist, Mr. Michael Hash, Deputy Administrator, Health Care Financing Administration. Mr. Hash, your written statement is a part of the record, as you know, and the Chair will turn the clock to 10 minutes to afford you an opportunity to explain to us what's happening. Please proceed, sir.

STATEMENT OF MICHAEL HASH, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. HASH. Thank you, Mr. Chairman. It's a pleasure to have the opportunity to participate in this important hearing today. We also want to join with your colleagues on the subcommittee in saying that this is a timely and appropriate hearing.

As you know, Mr. Chairman, currently some 6 million Medicare beneficiaries receive their benefits through managed care organizations. The Medicare+Choice program from the Balanced Budget Act builds on this experience. It offers beneficiaries the possibilities of new options such as provider sponsored organizations and preferred provider organizations.

It begins, of course, a 5-year transition to a new payment methodology that is designed to address flaws in the old payment system. It creates an annual coordinated open enrollment process and an educational program to reach out and help beneficiaries make informed choices among their health plan options.

And very importantly, Mr. Chairman, it raises the bar on quality and protections for both beneficiaries and providers. We believe that we are making solid progress in implementing this program. The comment period on our interim final regulation from last June closed just last week, and we are in the process of carefully evaluating the comments and the input we have received on that regulation.

We are also meeting on a regular basis with individual health plans, with industry representatives, and with advocates for Medicare beneficiaries to discuss ways to improve and strengthen the program. We are already making refinements based on these comments and consultations.

Yesterday, as you may have read or seen, we announced changes that will help plans to meet our requirements and those requirements called for in the Balanced Budget Act. Specifically, with regard to this, we are phasing in the quality improvement requirements identified in our June regulation, we are reducing the number of performance improvement projects that plans are required to conduct, and we are increasing plan flexibility for coordinating and conducting site visits to verify credentials of their providers.

We are also giving plans an additional year to implement compliance programs and to execute contracts with their providers that meet the new requirements that are set forth in our regulations.

These Medicare+Choice quality requirements remain, we believe, very similar to requirements of employers and other purchasers of health benefits in the type of accountability they are asking from health plans. We are simply making sure that plans have sufficient time to come into compliance with these requirements.

Mr. Chairman, we, too, are concerned, as you and your colleagues have said this morning, about the recent announcements by some plans to withdraw from certain counties. We are working to help affected beneficiaries move into other plans that may be available to them, and most importantly, to assure them of their continued coverage by the Medicare program and their rights as Medicare beneficiaries.

However, in some counties, there will be no other Medicare managed care options. We are especially concerned about the impact that this will have on disabled beneficiaries and those who have relied on prescription drug benefits that they may no longer be able to receive.

We are also worried about the potential erosion of the trust and the confidence that beneficiaries have placed in their managed care plans. At the same time, these widely publicized withdrawals in some ways can be misleading. It is important, I think, for us to step back and recognize that the overall trend is for expansion, as more beneficiaries and new plans continue to come into the program.

We now have pending at the Health Care Financing Administration, 48 new plan applications and 25 service area expansions.

Mr. Chairman, we have given careful consideration to the recent industry suggestions that we reopen the process for determining plan premium and benefit structures in order to address these withdrawals. Such an action, however, would let HMO's increase costs and cut benefits, even outside of the affected withdrawal counties. And, we have no assurances from plans that they would reverse any decisions to withdraw.

Reopening the process for all plans would require a rushed process in which we would essentially be forced to rubber stamp cost increases and benefit cuts. And, we would be unable to inform our beneficiaries about the changes in benefits and cost-sharing of the plans available to them in a timely manner.

We, therefore, concluded that reopening the process is not in beneficiaries' best interests. Furthermore, suggestions that payments are inadequate conflict with abundant evidence that plans are substantially overpaid. The Congressional Budget Office says plans will be overpaid some $31 billion over the next 10 years because the Balanced Budget Act does not allow for adjustments in the 1997 projection rates.

Our own Inspector General at the Department of Health and Human Services has told us that plans will be overpaid another $10 billion because payments include traditional Medicare fraud and abuse costs that are built into the plan rates. There can be no doubt that what we are paying plans is adequate.

While we are taking this position, we do remain, Mr. Chairman, committed to working with the Congress, with the industry, and with beneficiaries to discuss improvements in our process and in our requirements for future years. Obviously, we want to continue that collaboration with you and your staff, as well.

At this point, I would be happy to respond to any questions that you or other members of the subcommittee may have. Thank you very much.

[The prepared statement of Michael Hash follows:]

PREPARED STATEMENT OF MICHAEL HASH, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Chairman Bilirakis, Congressman Brown, distinguished Subcommittee members, thank you for inviting me here today to discuss the Medicare+Choice program.

Currently some six million Medicare beneficiaries receive their benefits through managed care organizations. The Medicare+Choice program builds on this experience by:

- offering beneficiaries the possibility of new options such as provider sponsored organizations (PSOs) and preferred provider organization (PPOs);
- initiating a five-year transition to a new payment methodology designed to address flaws in the previous adjusted average per capita cost (AAPCC) system;
- creating a coordinated open enrollment process and an educational program to help beneficiaries make informed choices among their options; and
- raising the bar on quality and protections for both beneficiaries and providers.

The regulation implementing the Medicare+Choice program was published in June, and the comment period closed on September 24, 1998. We are carefully evaluating this valuable input. We also are meeting regularly with industry representatives, including the American Association of Health Plans, the Blue Cross and Blue Shield Association, and others to discuss ways to improve the program. We already are making refinements based on these comments and discussions.

Yesterday we announced changes that will help plans meet quality improvement requirements called for in the Balanced Budget Act. We also announced that plans will have an additional year to implement compliance plans and complete contracts that incorporate new requirements with their current providers.

We have given careful consideration to industry suggestions that we reopen the process for determining plan premium and benefit structures, and have concluded that it would not be in the best interests of beneficiaries. We are not convinced that it would be in the best interest of beneficiaries to allow almost all HMOs to increase costs and decrease benefits to their Medicare enrollees. While we are taking this position, we remain committed to continue working with Congress and the industry to discuss potential improvements in the process for future years.

PROGRESS

Successful implementation of Medicare+Choice is a high priority for us. We have accomplished a great deal, including release of all Balanced Budget Act-mandated Medicare+Choice regulations.

- In September 1997, we issued 1998 plan payment rates based on the new BBA methodology. In March, we issued the 1999 plan payment rates.

- In April, we published a regulation establishing the definition of a PSO. In May, we published PSO solvency standard regulations that were developed through a negotiated rule-making process with a wide range of interested parties. We also published regulations on the process to apply for a federal waiver from state licensure.
- In May, we held the first meeting of the Medicare Competitive Pricing Advisory Commission. The Commission, which is chaired by General Motors Health Care Initiative Executive Director James Cubbin, met last week to decide on recommendations regarding key design features of the competitive pricing demonstration. The Commission will meet again later this month to select possible sites for the project.
- In June, we published the remaining Medicare+Choice regulations which detail requirements for plans and incorporate protections for beneficiaries and providers.
- In July, we began a "train-the-trainers" program for 700 individuals across the country in our education partner organizations. The goal is for them to teach others in their organizations and communities how to help beneficiaries understand their new options.
- As part of our eight-point National Medicare Education Program, we launched a consumer-friendly Internet site, Medicare.gov, where beneficiaries can find direct comparisons of the benefits and costs of plans available in their community. We have several additional steps scheduled, as well.
- This November, we will mail Medicare+Choice information to beneficiaries, open a toll-free call center, and provide other services to help beneficiaries understand the program.
- Also in November, we will provide training for plans on the new adjusted community rate (ACR) process which is used to review and approve plan benefit, premium and copayment structures. This new process addresses criticisms raised by the General Accounting Office and the HHS Inspector General and should reduce payment errors.
- By March 1999, we expect to formally report to Congress our method for "risk adjusting" payments to account for beneficiaries' health status, which we expect to implement on schedule in 2000. Risk adjustment will begin to address flaws in the payment system that have been documented by us, several Congressional agencies, and many other researchers. It also will ensure that plans have adequate resources to coordinate care for enrollees with serious health problems.
- We are working with beneficiary advocates and health plans to standardize plan summaries of benefits before the first annual coordinated open enrollment period in November 1999.

MEDICARE+CHOICE BENEFICIARY EDUCATION

Among the most important facets in implementing the Medicare+Choice program is helping beneficiaries understand their options so they can make informed decisions. Based on advice from the Institute of Medicine and our own work with over 30 beneficiary focus group sessions, we are phasing in our national educational campaign in order to refine efforts before the first full-scale education campaign and mailing mandated by the Balanced Budget Act in November 1999. We have an eight-point plan which we began this summer that includes: 1) beneficiary mailings; 2) toll-free telephone services; 3) Internet activities; 4) a national train-the-trainer program; 5) a national publicity campaign; 6) state and community-based special information campaigns; 7) enhanced beneficiary counseling from State Health Insurance Assistance Programs; and 8) targeted and comprehensive assessment of our education efforts.

We are first testing the whole system in five states—Arizona, Florida, Ohio, Oregon and Washington. The handbooks in these states include detailed information on Medicare+Choice options in general, as well as information specifically tailored to each market with side-by-side comparisons of costs and benefits for local plans. The call center will have personnel to answer specific questions. We plan to phase in call center access, with full nationwide service by August 1999. This phased approach allows us to gain experience with this new service, learn what kind of help beneficiaries want most, and determine how many customer service representatives will be needed. Outside these five states we will send beneficiaries a bulletin outlining Medicare+Choice options and other useful information about assistance for low-income beneficiaries, new preventive benefits, and how to obtain comparison data on plans in local markets. A national version of the full handbook will be sent to newly eligible beneficiaries and to any beneficiaries who request it; it is also already available on the Internet. The costs of beneficiary education are ongoing. Due to un-

certainty about the demands for Medicare+Choice information, we may need to review funding levels to ensure that beneficiaries are able to make informed decisions.

OUTREACH TO PLANS

We also making a concerted effort to help plans learn about the new program. We have had many informal meetings with industry representatives, which are ongoing. We also have had several formal meetings to help plans understand how to participate in the program.

- An outreach session held July 13-14 in Baltimore had approximately 350 attendees.
- An outreach session held July 21-22 in Chicago had more than 400 attendees.
- An outreach session held July 28-29 in Los Angeles had more than 400 attendees.
- A special outreach session held July 15 for those interested in offering Medical Savings Account plans was attended by representatives from 11 organizations.
- An outreach session on Medicare+Choice quality improvement requirements was held August 3-4 in Baltimore with 400 attendees.
- An outreach session on Medicare+Choice encounter data collection and risk adjustment methodologies was held September 17 in Baltimore with 200 attendees.

As of September 28th, we have 48 applications pending for new Medicare+Choice contracts and 25 pending applications for service area expansions from existing risk contractors. We have had only one entity withdraw its application following publication of the Medicare+Choice regulation. The applications we have received are for the most part from HMOs for coordinated care contracts, rather than the newer options authorized under the BBA. This is not surprising, given that the regulation was just published in June, and the time new plans need to develop networks, contracts, and business plans.

We have four applications pending from PSOs. Three have state licenses, and one obtained a federal waiver from state solvency standards. Two additional PSO waiver requests are pending. The extent to which provider groups will take advantage of this new option remains to be seen, but we are encouraged by the interest shown to date.

We have so far received only one PPO application. However, our revised quality improvement policy clarifies how standards apply to PPOs and should encourage more such plans to apply.

To date, we have no applications for MSA plans, which is not surprising given the cautious response to MSAs in the private sector. Insurers may show more interest in Medicare MSAs once they have more experience with MSAs in the private sector. Discussions with the industry lead us to believe that we will receive applications next year.

We also have no applications for private fee-for-service plans. This also is not surprising given that such plans would offer virtually unfettered access to services without medical review activities that insurers widely use to control costs. Such plans are now very rare in the private sector.

ENSURING QUALITY

The BBA includes important quality provisions for Medicare+Choice. It raises the bar by requiring most plans to not only monitor quality but also to improve quality. The new requirements will be phased in over the next several years.

This way beneficiaries can compare plans based on quality, and we can utilize Medicare's substantial market leverage to be a prudent purchaser and promote competition based on quality. We are actively working to incorporate quality assessment and improvement into traditional fee-for-service Medicare, as well, so beneficiaries will be able to make truly informed choices about all their options.

All Medicare+Choice plans must report objective, standardized measurements of how well they provide care and services. They will use HEDIS, the Health Plan Employer Data and information Set. HEDIS is the industry standard for measuring health plan performance, and it has been tailored specifically for the Medicare program. We have required Medicare HMO's to report HEDIS data since 1997. As a result of our experience with the initial round of HEDIS reporting, Medicare+Choice plans must now have HEDIS data audited before submission to ensure accuracy. We are disappointed that some plans have been unable to report reliable data on HEDIS measures despite substantial advance notice, and will work with plans to improve the quality of their reporting. We also will use CAHPS, the Consumer Assessment of Health Plans Survey, to objectively measure beneficiary satisfaction with plan care and service. We began requiring Medicare HMOs to conduct CAHPS

surveys this year. The results of both HEDIS and CAHPS will be formatted so beneficiaries can make direct, apples-to-apples comparisons among their plan options.

Plans with provider networks must conduct performance improvement projects and over time achieve demonstrable and sustained improvement. Eventually these plans, except for network-based Medical Savings Account plans, will have to meet minimum performance standards. Establishing minimum performance standards is important because data now starting to come in from the objective HEDIS performance measures show wide variation in how well plans provide care. For example, according to HEDIS data from existing Medicare managed care plans, 90 percent of women in some plans get yearly mammograms, while less than 50 percent get this essential screening service in other plans. Also, the latest National Committee on Quality Assurance *State of Managed Care Quality* report shows that, despite the promise and capacity of managed care to improve quality, the managed care industry's overall performance on HEDIS measures was "essentially unchanged" from 1996 to 1997.

That same National Committee on Quality Assurance report documents the potential of managed care to improve quality and save lives. The percentage of plan physicians that gave advice to quit smoking rose industry wide from 61 percent to 64 percent. The Centers for Disease Control calculates that this one improvement in health care quality alone will save 1,520 lives. We must proceed with Medicare+Choice quality improvement requirements in order for the promise of managed care to be met across the board.

HELPING PLANS COMPLY

We recognize that it takes time for plans to adapt to the quality improvement requirements, and that a Teaming curve is involved. Therefore, we are making several changes from our draft proposal to help plans comply.

- We are reducing the number of performance improvement projects that plans must conduct to just two per year. This workload is comparable to standards imposed by private sector accrediting organizations. Plans can choose projects that they believe will target their enrollees' specific concerns.
- We are permitting waivers of mandatory participation in a national project each year, and allowing plans to substitute any related ongoing projects of their own. In 1999, the national HCFA-sponsored project will focus on diabetes, but plans with existing diabetes projects can instead continue these projects without obtaining preapproval from HCFA.
- We are phasing in quality improvement requirements by giving plans three years before they must achieve demonstrable improvement. In the first contract year, plans need only select a topic, establish performance indicators, and collect baseline data.
- We are clarifying the schedule for compliance with minimum performance level requirements. We intend to establish these levels in 1999, first measure compliance in 2000, and require plans to have achieved demonstrable improvement in 2001.
- We are giving plans discretion as to where they conduct site visits for provider credentialing, rather than mandating site visits to each provider location. Plans also have discretion in developing criteria for site visits, and they may delegate these functions.
- We are increasing flexibility in coordinating care by allowing primary care providers, a team of providers, or an employee who is a health care professional to conduct this function.

Phasing in enforcement is a normal and prudent course of business when implementing new programs or rules. The Medicare+Choice quality improvement requirements remain similar to those in the private sector. We are simply making sure plans have sufficient time to come into compliance.

Plans that do not have defined provider networks, such as non-network MSA plans and private fee-for-service plans, must report the same standardized performance measures as all other plans. These non-network plans also must evaluate the continuity and coordination of care that enrollees receive. However, the BBA excludes them from the quality improvement requirements.

Appropriate flexibility will be provided so plans with networks that are less structured than traditional HMOs, such as PPOs, can meet these requirements. The regulation preamble makes clear that we are not adopting a "one size fits all" approach. Our quality improvement systems will be sensitive to different plan structures and their different abilities to affect provider behavior.

BENEFICIARY AND PROVIDER PROTECTIONS

Other provisions in Medicare+Choice address common complaints about health plans, both by consumers and providers.

Time frames for appeals are significantly tightened for decisions to deny care. Plans must issue initial decisions within 14 days, down from a previous maximum of 60 days. If a beneficiary appeals the initial decision, the plan must issue a ruling within 30 days, also down from 60 days. Plans must rule within 72 hours on denial-of-care decisions, including terminations of care, that could jeopardize the life, health or ability of the enrollee to regain maximum function. For all service-related decisions, extensions of up to 14 days may be permitted if the organization justifies a need and explains how the delay is in the enrollee's interest. The rules also set the same 72 hour and 30 day limits on Medicare's independent appeal body, where appeals are automatically forwarded when a plan denies a beneficiary request.

Emergency room visit copayments can be no higher than $50. Plans must cover emergency room visits for situations that a "prudent layperson" would consider an emergency. And they must pay for any services needed to stabilize a patient until discharge, a plan physician arrives, or an emergency room physician agrees with a plan physician on transfer of the patient to another facility. They must return emergency room calls seeking care authorizations for post-stabilization care within one hour.

Plans also are prohibited from having "gag rules" that limit what providers can tell patients about treatment options. They may not discourage enrollment or deny, limit or condition the coverage because of medical history, genetic information, mental or physical illness, disability, or prior use of services. They must provide direct access to specialists without a new primary care referral for each consultation in a given treatment plan for patients with complex or serious medical problems. And they must provide women access without primary care referrals to women's health specialists in plan networks for women's routine and preventive care, such as Pap smears and breast exams.

There are also important protections for providers. Plans must explain decisions to cancel or refuse to sign contracts with physicians and other health professionals, and let providers request plan review of decisions to remove them from networks. Plans also are prohibited from discriminating against any class of providers.

PLAN PAYMENT

The BBA put in place a new payment system which addresses many of the problems with the previous adjusted average per capita cost payment system. Once fully implemented it will:

- break the link between local fee-for-service costs and county payment, thus dramatically reducing disparities in rates across the country;
- replace unpredictable fluctuations in the individual county rates with a more predictable national update factor; and
- eliminate overpayments that were estimated to cost Medicare up to $2 billion a year.

Under the BBA system, a rate for a particular county is the greater of three possible rates: a new minimum or "floor" payment; a minimum 2 percent increase over the previous year's rate, or a blend of the county rate and an input priced adjusted national rate. The new system is phased in over five years, and therefore has several different moving parts. Medical education costs, which had been included in HMO K40 payments under the old system, are carved out of county rates over the five-year transition and paid instead directly to teaching hospitals. The blend of county and national rates phases up to a 50/50 balance over the same five years. The national rate, local rates and the minimum payment amount are annually updated based on per capita Medicare growth. On top of these moving parts, the BBA mandates budget neutrality so total payments under the new system equal what total payments would have been if payment were based on county rates. In order to protect the floor payment and a minimum 2 percent increase, the law stipulates that the budget neutrality adjustment is applied only to the blended rates.

For 1998, the HCFA Actuary's initial projection of payments under this new system before the budget neutrality provision was applied was $250 million above what payments would have been if payment were based on county rates. For 1999 it was $300 million above what payments would have been if payment were based on county rates. Because the budget neutrality provision is applied only to the blended rates, payment for counties that would have received the blended rate by law had to be decreased to make up that difference. For 1998 and 1999, this process decreased blended rates to the point that they were below either the floor payment

or the minimum 2 percent increase in all cases. Since payments are the greater of either the floor, the minimum increase, or the blend, no county rate is based on the blend. Furthermore, because the statute stipulates that the budget neutrality provision can be applied only to blend payments, total payments to plans based on the floor payment or the minimum 2 percent increase exceed budget neutrality by $95 million in 1998 and $80 million in 1999. We have no authority to address this.

We are disappointed that the blended rates cannot be applied in 1998 and 1999, as the blend rate is expected to encourage Medicare+Choice offerings in rural and other low cost areas. However, it is important to keep in mind that the budget neutrality adjustment affects blended rates only in the year in which it is applied. So, with the blend rising to a 50/50 mix of national and local rates by 2002, counties that have been receiving rates that are low but higher than the new floor will eventually receive a significant increase from the blend. At this point, we project that payments based on the blend will survive the budget neutrality provision and be implemented in 2000.

RISK ADJUSTMENT

In the Year 2000, we also will begin to incorporate risk adjustment for enrollee health status into our plan payments. Plans will no longer be paid the same for a healthy beneficiary with minimal health care needs as for one with chronic conditions and substantial health care needs. Payment is now adjusted only for age, sex, and whether the beneficiary is in an institution or also enrolled in Medicaid. For example, in Kings County, NY, we now pay the same $747 for any 76-year-old male beneficiary, regardless of whether they have a serious heart condition or no medical problems at all. Based on the recently proposed methodology for risk adjustment, payment in Kings County for a 76-year-old, male beneficiary with no health problems would be $621, while payment for a 76-year-old male with coronary artery disease hospitalized for a heart attack would increase substantially to $1208, and payment for a 76-year-old male hospitalized for lung cancer would increase to $2317. Thus, plans will have an incentive to enroll beneficiaries with serious health problems who may be most able to benefit from the care coordination services plans promise to provide.

The risk adjustment system we will implement will use inpatient data that plans can readily produce. As plans improve their capacity to provide more detailed data, we will move to a more sensitive risk adjustment methodology that includes outpatient data and non-hospitalized beneficiaries with serious chronic conditions such as diabetes or rheumatoid arthritis. We will provide each plan with an estimate of risk adjustment's impact on their payments early next year. In implementing risk adjustment, we will consider impacts on plan benefits and premium packages. We will fully inform the Subcommittee of our plans when final impact analyses are completed later this year.

Risk adjustment will do two important things. First, it will reduce the incentive for "cherry picking," or enrolling healthy seniors while avoiding enrollment of higher cost beneficiaries. Secondly, it will help end overpayments due to plan cherry picking and thus reduce total overpayment to plans.

OVERPAYMENT TO PLANS

There is considerable evidence that we have overpaid plans and continue to overpay plans, in part because payments are not adjusted for risk, and for other reasons as well.

- The Physician Payment Review Commission, in its 1997 Annual Report to Congress, estimated that Medicare has been making up to $2 billion a year in excess payments to managed care plans. This Congressional advisory body notes that, unlike the private sector where managed care has slowed health care cost growth, managed care has increased Medicare program outlays. The Commission's 1996 Report found that those who enroll in managed care tend to be healthy and those who disenroll tend to be unhealthy, exacerbating Medicare losses.
- Mathematica Policy Research, which has conducted several studies on Medicare HMOs, says care of Medicare beneficiaries in HMOs costs only 85 percent as much as care for those who remain in traditional fee-for-service Medicare. That is 10 percent less than the 95 percent of the average fee-for-service costs plans were being paid.
- The Congressional Budget Office has said managed care plans could offer Medicare benefits for 87 percent of Medicare fee-for-service costs, even though they were paid 95 percent.

- The HHS Inspector General, in a recent report, indicated that Medicare HMOs overstated their anticipated administrative costs in 1994, 1995 and 1996 by as much as $2 billion.
- The HHS Inspector General also recently reported that payments to plans are inflated because they include traditional Medicare's fraud and abuse costs, which managed care plans should be able to avoid. The IG says inclusion of fraud and abuse costs in plan payments will result in another $5 billion in excess payment to plans in 2002, and another $10 billion in 2007.
- As described above, the payment methodology stipulated in the BBA, in spite of its own budget neutrality provision, results in total payments that exceed budget neutrality by $95 million in 1998 and $80 million in 1999.
- The BBA also did not allow us to adjust 1998 rates for errors in projections upon which 1997 plan rates were based. Since the 1997 rates were overstated by nearly 3 percent, the base for all future M+C rates will be permanently overstated by 3 percent. The Congressional Budget Office says that, because of this, Medicare will overpay plans about $8.7 billion over the next five years, and $31 billion over the next 10 years.

Given such extensive evidence of overpayment, there can be no doubt that what we are paying plans is adequate.

SERVICE AREA REDUCTIONS

We are concerned about the recent trend among plans to withdraw from counties that have somewhat lower payment rates than adjacent counties. As of September 30, 33 of the 347 risk plans currently in Medicare had announced that they are not renewing their Medicare contracts, affecting a total of 195,087 beneficiaries. Another 31 plans are reducing service areas, affecting 43,729 beneficiaries. These terminations and service area reductions affect 318 counties, and we are working to help affected beneficiaries move into other plans available to them. However, in 63 of these counties there are no other Medicare HMOs, leaving 27,850 beneficiaries with no options other than to go back to traditional Medicare. These plan business decisions may cause significant disruptions to beneficiaries. While we are working through our regional offices to help beneficiaries transition to other plans or back to traditional Medicare, we are particularly concerned about the impact on disabled beneficiaries and those who have relied on prescription drug benefits that they may no longer be able to receive.

These widely publicized withdrawals can be misleading, though. The overall trend is for expansion, as more beneficiaries and more counties will have managed care options in 1999 than in 1998. We now have 48 new plan applications and 25 service area expansion applications pending.

Average payment to plans nationwide is $471. Payment in counties where plans are withdrawing averages $467.10 and ranges from the floor payment of $379.84 to $795.35. Payment in counties where withdrawing plans leave beneficiaries with no managed care options averages $435.03 and ranges from the floor payment of $379.84 to $720.81.

As stated above, we have given careful consideration to industry suggestions that we reopen the process for determining plan premium and benefit structures, and concluded that it would not be in the best interests of beneficiaries. We have no assurances from plans that reopening the process would result in reversals of any decisions to reduce service areas or not renew contracts. We do know that such revisions are likely to adversely affect the millions of enrollees outside of the counties in question by reducing benefits and increasing premiums and cost-sharing. We see little benefit in allowing almost all HMOs to increase costs and decrease benefits to their Medicare enrollees. Reopening the process for all the plans and plan options in Medicare, which total more than 900, would require a rushed process in which we would essentially be forced to rubber-stamp plan proposals to increase costs or reduce benefits. This would be unfair to beneficiaries and undermine the integrity of the process for establishing premium and benefit packages. It also could pose problems for our beneficiary education efforts this fall, since changes could make materials describing plan benefits and costs that have already been produced incorrect.

Furthermore, suggestions that payment rates may be inadequate contradict abundant evidence that plans continue to be substantially overpaid. Risk adjustment provisions have not yet been implemented to address overpayments based on enrollee health. There is substantial evidence that we have overpaid and continue to overpay plans, including the Congressional Budget Office estimate that plans will be overpaid $31 billion over the next 10 years because the BBA does not allow adjustments

for errors in the projections upon which 1997 plan rates were based. Again, there can be no doubt that what we are paying plans is adequate.

It is unfortunate that this question was raised at such a late date. We are puzzled by the fact that cost trends that were included by plans in their submissions to the Federal Employee Health Benefits Program in late May were not included by the same plans in their submission to us that same month. We would like to continue working with Congress and the industry to discuss potential improvements in the process for future years that would be allow us to produce accurate and timely educational materials for the November open enrollment period.

CONCLUSION

We are making substantial progress in implementing the Medicare+Choice regulation. We are responding to comments on our regulations with changes that will help the industry participate without compromising Congressional intent that Medicare promote quality and be a prudent purchaser. We are disturbed by the spate of withdrawals by plans from certain counties and are considering options to ameliorate the disruption these business decisions by plans cause beneficiaries. We are also concerned about the message sent to beneficiaries about the reliability of managed care plans. However, more plans continue to come into the program, more beneficiaries continue to sign up, and growth overall should continue at a substantial rate. I would be happy to answer any questions you might have.

Mr. BILIRAKIS. Thank you, Michael. We have all expressed concern with what appears to be happening. We have yet to hear from the plans themselves, and I am hopeful that either you or one of your HCFA representatives will remain in the hearing room while they testify.

But a lot of what we've heard is that some of this concern on the part of the plans has to do with the impact that the so-called megareg will have on the market. Now, even though the megareg was issued as an interim final rule which technically exempts HCFA, as I understand it, from complying with the Regulatory Flexibility Act, I would like to ask you to conduct an analysis for us.

And I would ask for your commitment here today. Will you commit to us today to conduct a full economic impact analysis of the Medicare+Choice megareg, which will include a full assessment of the impact of this rule on health coverage providers?

Mr. HASH. Mr. Chairman, I would say I think we want to work with you. I believe that's an appropriate request for us and we would be happy to take a look at how we might more fully assess the impact.

Mr. BILIRAKIS. You do agree that it's significant that we take a look at that, because we are trying to determine here where maybe the solutions to these problems might be.

Mr. HASH. I think, in the spirit of working together with you, that we need to take a look at it.

Mr. BILIRAKIS. All right. Michael, we've got to go to a timeline on this. Can you commit to producing this analysis within 10 working days?

Mr. HASH. Mr. Chairman, I don't think that is feasible, but I'd like to work with you to do it as quickly as possible.

Mr. BILIRAKIS. As quickly as possible. Well, the period of time is significant because in the first place, we are not going to adjourn sine die; we'll be back. And I am not sure, but we may be able to address this at that time, but certainly by the first part of next year.

So I would hope that the staff here will keep me advised. I would hope you will keep up with them in terms of the progress you are making. I don't want to hold you to 10 days now; that might be unfair. But at the same time, certainly something not too many days after that.

Mr. HASH. I understand, Mr. Chairman.

[The following was received for the record:]

A regulatory impact analysis was published as part of the regulation in the *Federal Register* on June 26, 1998, pages 35044 to 35053. We will continue to work with your staff to identify any other analyses that may be useful.

Mr. BILIRAKIS. September 24 was the closing date for comments on the regulation. Have you been able to summarize the comments that you received?

Mr. HASH. Mr. Chairman, not yet. I think we are in the process of doing that right now to, in effect, look across the large number of comments that we had, pull them together within the categories that they address. We expect to have such a summary soon, but as you noted, the comment period just did close and we are in the process of doing that now.

[The following was received for the record:]

SUMMARY OF COMMENTS ON THE MEDICARE+CHOICE REGULATION (HCFA-1030-IFC)

NUMBER AND TYPE OF COMMENTS

We received 85 items of correspondence containing comments on the June 26, 1998 Medicare+Choice interim final rule. An approximate breakdown of the commenters is as follows:

Managed care organizations, and other industry representatives 20+
Representatives of physicians and other health care professionals 20+
Beneficiary advocate groups 10+
Representatives of hospitals and other providers 10+
Insurance companies 5
Law firms or organizations 5
States 5
Others (accrediting and peer review organizations, MedPAC, Congress) 5

Content of Comments

Consistent with the scope of the June 26 rule, most of the comments addressed multiple issues, often in great detail. Based on our preliminary review of the comments, listed below are the five areas of the regulation that generated the most concern (30-50 comments), along with a brief overview of the comments:

- Access issues—These include requirements concerning initial assessments of enrollees' health care needs, timely pre-approval of post-stabilization services, and notification responsibilities when an organization terminates its relationship with a specialist. In general, industry commenters generally opposed these requirements as published while beneficiary advocates supported them.
- Quality improvement standards—Again, industry commenters objected to what they viewed as overly burdensome quality assurance requirements, while consumer representatives either supported the regulatory provisions or recommended even more stringent requirements.
- Payment rates and service area—Although they recognized that HCFA had little discretion in this regard, industry commenters indicated that the payment levels established under the BBA could discourage plan participation in the Medicare+Choice program. Many of these commenters requested that HCFA continue to allow plans the flexibility to submit separate adjusted community rate (ACR) proposals for portions of their service areas with different reimbursement rates.
- Provider participation rules—Industry commenters strongly objected to the scope of the provider participation requirements, including both the provision that these requirements extended to health care professionals other than physicians as well as what they saw as overly broad and burdensome provider participa-

tion procedures. Physician representatives generally supported the required procedures, but objected to expanding them to other health care professionals; not surprisingly, practitioners other than physicians strongly supported such an expansion.

- Appeals and grievances—Consumer advocates generally supported the reduced timeframes for conducting appeals of organization determinations regarding requests for service; industry commenters expressed reservations or objections.

Other issues that also generated substantial numbers of comments (10+) included:

- Eligibility, election, and enrollment policies
- Requirements concerning the information a plan must provide
- Marketing restrictions
- Risk adjustment methodology and encounter data submission
- Contractual requirements
- Preemption of State law by Federal law
- Point of service options
- Deeming and accreditation provisions
- May 1 deadline for ACR submissions and capacity waivers
- Notification of noncoverage of hospital care
- User fees

Mr. BILIRAKIS. All right. In developing your quality improvement standards, how much did you rely on private sector approaches to quality? In what respects did you take a different route, and if so, on what basis?

Mr. HASH. Mr. Chairman, I am glad you asked that question, because I think there has been some misunderstanding about the basis of our requirements in the area of quality. I want to say at the outset, I think it's accurate to say that what we are asking plans for in a general way is consistent with what large employers and other purchasers of health benefits are asking in the way of quality accountability for the plans that they do business with.

More specifically—and I'd be happy to submit this for the record—we have done a comparative chart which examines our quality requirements in comparison with the requirements of the National Committee of Quality Assurance, which as you know, is a private accrediting agency for managed care organizations. I think you would see from that comparison that essentially, on item by item, we are comparable to the requirements of NCQA.

Mr. BILIRAKIS. Is that chart a part of your written statement?

Mr. HASH. No, I'd be happy to submit it for the record.

Mr. BILIRAKIS. If you would. We have a chart here, and I'm not sure if this is the one you are referring to.

Mr. HASH. I believe it is, yes. That's correct, Mr. Chairman, that is it.

Mr. BILIRAKIS. Then, without objection, that will be made a part of your statement.

[The information referred to follows:]

COMPARISON CHART OF NCQA vs HCFA

	NCQA	QISMC
Report on HEDIS measures	yes	yes
Minimum performance on HEDIS measures	required for accreditation decision	Required for contract
Improvement Projects	Required	same
Burden	6 projects in 3 years	same
Meaningful Improvement	required	Defined as improvement in performance gap by 10%
Statistical Significance of sampling	Suggests .10 level	Requires .10 level
Utilization Review	physician review required	same
Continuity of Care following physician termination (for other than quality concerns)	60 days for treatment of illness or up until post-partum period for OB	less stringent -- requires notification of beneficiary (NCQA standard statutorily prohibited in Medicare)
Access standards	policies and procedures required	additional requirements with regard to routine preventive services for women and patient's with complex or serious medical conditions
Initial Health assessment	none required	required
Credentialing - initial - primary source verification	yes	same
- site visits	yes -- all primary care providers and OB/GYN	less onerous -- plan develops its policy
Recredentialing - frequency and re-verification	every 2 years	same
- site visits	to primary care practitioners with more than 50 MCO members	less onerous -- plan develops its policy

Mr. BILIRAKIS. Then regarding the quality standards, I think I am gathering from your statement that most of the plans participating in the program today can meet those standards, is that correct?

Mr. HASH. We believe so, Mr. Chairman.

Mr. BILIRAKIS. My time has expired. Mr. Brown. Thank you, sir.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. Hash, plans have argued and will continue to today, that the financial burden for complying with the regulatory requirements from the Balanced Budget Act is staggering. They said that plans and providers will drop out of Medicare and are dropping out of Medicare because they can't afford to make the changes necessary to be in compliance.

But in your testimony, and as we heard several months ago, you stated that an HHS Inspector General report in July concluded the Medicare overpayments due to inflated projections of Medicare's share of plans' administrative costs amounted to more than $1 billion per year. And according to the Congressional Budget Office in 1997, when health inflation was less than HCFA estimated, managed care plans were overpaid about 3 percent, and the Balanced Budget Act took the authority away to recover that overpayment.

CBO estimated it cost Medicare $8 plus billion over 5 years and $31 billion over 10 years. It seems if Medicare is overpaying plans, these plans should not have problems implementing the requirements established in the BBA to improve quality, especially when many of the good plans represented here today, and just many of the good plans generally, are already doing many of these things.

Comment on that, if you would.

Mr. HASH. Yes, sir, Mr. Brown. I think you have identified some of the evidence that exists that suggests that our rates are in excess of what is required for plans to provide the Medicare benefit package. In fact, I think our most recent data suggests that if you add up the value of the extra benefits that the managed care plans are providing to beneficiaries beyond the Medicare package, it's some $4 billion in the most recent year, or about 20 percent of what we pay totally to managed care plans.

So plans have been offering benefits that have a significant cost and value to our beneficiaries that are above the value of what we are paying for the basic Medicare package.

So there is significant evidence that there's an opportunity for plans to meet our requirements without additional funding.

Mr. BROWN. At the end of my opening statement, I mentioned the sort of privatization of Medicare, and in a more theoretical, maybe philosophical way, but how in many cases, Medicare managed care plans are cream skimming and encouraging the youngest and healthiest beneficiaries to join those plans, leading ultimately and inexorably perhaps, to a very divided Medicare program with the youngest and healthiest and most affluent in some sort of private insurance plan with money being take out of the health care system, for large salaries, for marketing, and for profits. While the sickest and the oldest and the poorest are left in what is increasingly looking like Welfare program that is called Medicare.

Are we moving in a direction of greater involvement and larger numbers of people in Medicare for profit managed care plans?

Mr. HASH. Mr. Brown, I think there is some grounds for concern here, but I think we need to step back and look at what we hope will happen over time. First, as the number of Medicare beneficiaries—and they have been large in recent times—elect voluntarily to join managed care plans, then those plans are going to increasingly have a population of enrollees that is representative of the spectrum of health care conditions in the Medicare population.

So there is an expectation that over time, they will have a more representative group of enrollees in terms of their health care costs.

Second, and not unimportantly, the BBA provides authority-and we intend to implement it—which will adjust the payments in the future to plans on the basis of data that reflects the health care needs of individual enrollees. This is the so-called risk adjustment methodology that we will factor into payments to health plans in the future.

And that will help to do two things, Mr. Brown. That is, it will help to assure that we are paying appropriately in terms of the expected cost of enrollees, and it will create the proper incentives, we believe, for plans not to avoid enrolling individuals who may have high costs or heavy health care needs, because they would be more adequately paid for those patients.

Mr. BROWN. Could I follow up with one brief question, Mr. Chairman.

Mr. BILIRAKIS. By all means.

Mr. BROWN. Thank you. But while you are claiming a more representative group is likely as Medicare or managed care expands, increases, and enlarges, if you take any specific group of people or any specific individual and multiply it out however many times, isn't there some proclivity for people to join Medicare managed care private for-profit plans when they are 65 and 70 and generally not very sick, and leave that when they need more specialty care, when Medicare fee-for-service is more attractive, when they are 75 and 80 and more likely to get sick, to the point that you are 65 and the insurance company insures you, and when you are 80, the taxpayers pay for you.

Isn't that likely to happen if you track a large number of individual cases that way?

Mr. HASH. There is evidence that those who disenroll from managed care plans have above average health care costs and expenses, and that would lead you in that direction.

I think, in fairness, we are a little early in making a judgment on this. I think some of the reasons why we have younger people in health plans in Medicare now is because this is the new enrollees in Medicare who have had broader experience in their working years with managed care plans and have continued to want to be in them.

Whereas, our older Medicare population are individuals who, during their working period, may not have had such experiences and are more comfortable in the traditional fee-for-service. So I think the jury is somewhat still out on this.

Mr. BILIRAKIS. I thank the gentleman. Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman. Mr. Chairman, I want to editorialize for a moment. I voted for campaign finance reform,

especially because of the soft money provisions. Unfortunately, the Clinton scandal, has allowed that issue to be swept off the table in the Senate.

But then I read today on the front page of the Wall Street Journal how one of the congressional campaign committees is inviting a select group of health care industry leaders to a meeting with a ticket price of $25,000 each for an hour. That would exceed $400 a minute per person for the fundraiser.

And then I read on page 4 of the National Journal's Congress Daily that Congress could still act on the payment concerns of Medicare managed care plans. I think this demonstrates that the public should be outraged that campaign finance reform has been swept off the table for this year.

I sincerely hope that we bring this issue up again in the coming months, because this is a blight on our political system.

Let me move on to questions for you, Mr. Hash. As I alluded to in my opening statement, there is ample evidence that Medicare has been overpaying risk contractors by literally billions and billions of dollars. Your written testimony contains an excellent summation of the extensive research on this point, including the fact that CBO estimates that the simple inability to correct a 3-percent mistake in the 1997 rates will result in $31 billion in overpayments for the next 10 years.

Mr. Hash, I am glad to know that HCFA shares my concerns about these overpayments. Can you tell us what you are doing to prevent the Medicare trust funds from being further squandered in these ways, and whether HCFA has any means of recouping prior overpayments?

Mr. HASH. Mr. Ganske, let me do that in sort of three ways, and these relate to what I think are pieces of the evidence that suggests there may have been, and are, overpayments.

On the issue of favorable selection, in which there are studies that suggest that because our payments do not adequately adjust for the health care needs of enrollees in managed care plans, that we are overpaying those plans. As I noted a moment ago, what we are doing—and the Congress actually provided the authority for this—is that we are developing a risk adjustment payment methodology that will make those payments over time more precise and more in line with the expected need for health care services of Medicare beneficiaries in managed care plans.

Second, there has been some evidence that we had a methodology in place that actually permitted health plans to overstate the allocation of administrative costs to the Medicare program in their annual estimate of the cost of providing the Medicare benefit package, and that was picked up in the rates.

In our rule that we published in June, we revised that methodology, and beginning with the submissions that plans will give us next spring, there will be a much different requirement with regard to the treatment of administrative costs.

With regard to overstated rates from the 1997 misestimation, as we've noted, the statute has not allowed us to make an adjustment for that particular overstatement in plan rates.

And last, with regard to the potential that fraud and abuse costs in the traditional program, from which managed care plan rates

are derived, may, in fact, have inflated rates we have, redoubled our efforts in the fraud and abuse area in order to reduce the extent to which our programs are taken advantage of by unscrupulous providers, whether they be managed care or fee for service providers to the Medicare program.

Mr. GANSKE. Last week, Mr. Hash, AAHP and others asked Medicare to allow them to re-submit their adjusted community rates. The Balanced Budget Act set a statutory deadline of May 1. I did not think that request was very reasonable. Health plans are sophisticated, and have known for some time that health care costs are rising.

They have shown plenty of aptitude in making the same long-range forecasts in the Federal Employees' Health Benefit Plan. Moreover, the costs would be borne by seniors in the form of higher premiums and lower payments, as suggested by the AAHP request.

On the next panel, the health plans will argue that they need to refile because new regulations issued by HCFA have caused their costs to increase. I would be interested in your comments on that, particularly as to whether any such cost increases would be large enough to offset the amounts the plans are already being overpaid as a result of favorable selection, miscalculation of administrative costs, and including fee-for-services fraud rates in calculating capitation.

Mr. HASH. Mr. Ganske, in terms of the quality requirements and other requirements of our June reg, it is our view that those requirements do not translate into increased costs for plans that are significant.

Our view on that, as the chairman noted at the outset, is that for the most part, the requirements in our regulation are ones which many plans are already meeting, either on their own or due to other requirements in State law or wherever. So actually, we don't agree that the costs that may come from compliance with our June regulation are significant enough to require adjustment in plan filings this fall.

Mr. GANSKE. Mr. Chairman, will we have time for a second round?

Mr. UPTON [presiding]. I would hope so.

Mr. GANSKE. Thank you.

Mr. UPTON. The gentleman from California. No, the gentleman from New Jersey.

Mr. PALLONE. Thank you, Mr. Chairman. I wanted to ask Mr. Hash, I understand HCFA has received a number of comments from plans in response to the quality guidelines they issued. And you mentioned in your testimony that HCFA has responded to plan comments by revising some of these guidelines.

Would you just walk us through those changes you mentioned, and tell us what are the implications for beneficiaries, as well as plans. And I guess I hope that you won't diminish the high quality standards that Congress intended, and I think seniors deserve because of these changes. So keep that in mind.

Mr. HASH. Yes, I will try to do this briefly, in the interest of time, Mr. Pallone. In the area of the quality improvement system for managed care, the so-called QISMC document, as I think you noted, earlier this week we released a revised version of that docu-

ment. And in that revised document, we indicated that the number of quality improvement projects that plans had to undertake each year was being reduced, and that the requirement for all plans to participate in at least one national health plan quality improvement project could be waived if the plan was already doing a project in that same area.

We also indicated that we would have a longer phase in for compliance with the demonstration of sustainable and measurable improvement in quality. We indicated that we would allow a 1-year delay in meeting the requirement for a compliance plan within each of the plans. We also indicated that the requirement for credentialing of providers that health plans are required to do could be done in a more flexible manner than we had indicated earlier.

And we indicated that, in terms of meeting a plan requirement for the coordination of care, that they could do that in a variety of ways and not just on the basis of having appointed a primary care gatekeeping physician.

These are somewhat arcane, but very important steps in terms of holding plans accountable for demonstrating that they are improving the quality of care. We don't think the modifications we've made in terms of phasing in, and in terms of reduction in the volume of this activity will, in fact, impinge on the quality of care that will be available to plans that are contracting with us.

Mr. PALLONE. Let me ask you, one of these quality improvement projects related to diabetes screening. I don't know if you just mentioned it, but it went from, what, seven to two or something like that?

Mr. HASH. Well, overall in the earlier document that was released last January, there was a guidance in there that said plans would have to undertake at least seven projects for quality improvement each year. That requirement is now two, one of which is expected to be a national project, and for 1999, that project will focus on diabetes.

Plans will be required to participate in that unless otherwise they are engaged in a quality improvement project related to diabetes and they want to continue on that, and they come to us and ask for a waiver from that requirement on diabetes. The second project would be one of their own choosing.

Mr. PALLONE. Okay. Well, I am concerned about this. Obviously, you are making these changes because you think they are not going to be negative, but a lot of times the kind of flexibility or the kind of changes you are talking about, I guess the jury is out, so to speak. But we need to keep in mind that these things were put in because of our concerns, and we want to make sure that we have high quality.

Mr. HASH. I agree, Mr. Pallone. The only other thing I would point out here is that in addition to quality improvement projects that plans are expected to undertake, we also have them reporting standardized measures that we can use to judge their performance in other ways. So our ability to evaluate and hold plans accountable for quality health care is not limited only to their performance on quality improvement projects.

It is also related to the data that they're reporting to us, the so-called HEDIS data, which will indicate to us in a variety of areas how they are performing in terms of serving their beneficiaries' needs.

Mr. PALLONE. Let me just turn to the disclosure issue that I mentioned in my opening statement. I am so concerned that seniors don't know what they are getting into with regard to these choices for HMO's.

If I could, Mr. Chairman, what kind of information does a plan have to disclose when it pulls out of a market, and what are its obligations to the enrollees? I am just afraid that seniors don't understand that even if the plan continues and they don't pull out of Medicare, that a lot of the benefits don't necessarily have to continue from year to year.

To what extent are they informed about that, or is there any outreach to inform them of that?

Mr. HASH. Yes, Mr. Pallone, I have in my written statement a lot of detail about the efforts that we've undertaken at the Health Care Financing Administration to provide educational materials to our beneficiaries, not only about traditional Medicare, but now about what these choices mean; issues related to the fact that they may receive extra benefits, but those extra benefits are not necessarily going to be there year in and year out, that they may change over time, that that is a plan option, if you will, when it comes to supplemental benefits.

So we are trying in a variety of ways to reach out to our beneficiaries to make sure that they understand the possible changes that might confront them.

In answer to your specific question about how plans notify their enrollees when they are intending to leave either a service area or to pull out altogether from participation in Medicare: they have to first notify us 90 days in advance of the termination of their agreement with us, and then they have to provide at least a 60-day notice to all of their enrollees.

In addition, we are working with our partners in the States and in local communities to make sure that individuals who are affected by plan pullouts have available to them information about transition to other plans, transition back to the traditional Medicare program, and their opportunities to purchase supplemental coverage. That's a major challenge we have, which has, of course, been heightened significantly by the recent announcement of the plan withdrawals.

But we are deeply committed to meeting our responsibilities to provide that kind of information to beneficiaries who are facing these kinds of abrupt changes.

Mr. PALLONE. Thank you.

Mr. UPTON. The gentleman's time has expired. The gentleman from California, Mr. Bilbray.

Mr. BILBRAY. Thank you. What do you believe the dropout rate in certain markets are being driven by? Do you think that the payment rate is the major driving force?

Mr. HASH. I think it's difficult to generalize about this. I think, as you know, we have over 350 participating plans. I think they are largely making business decisions which, in part, are based on ex-

pectations about Medicare payments; in part, based on the circumstances in terms of competition within the markets they are serving.

I think there are a variety of factors that enter into their judgment, and I wouldn't presume to know exactly what the major factor is that's driving these decisions. But I think what we all recognize is that they are making what they believe to be the most prudent business decisions for themselves.

Mr. BILBRAY. My colleague, Mr. Waxman, who is also from California, was pointing out that Southern California probably has the largest penetration of managed care of any place in the country, but now in the last 12 months, we've seen this issue raise up to where you are seeing major providers that are basically feeling it is not viable to provide these services in the future.

Has California created this problem themselves, or are we talking about basically the difference in markets and the difference in reimbursement rates, maybe, driving those decisions?

Mr. HASH. I don't think it is a California-induced problem.

Mr. BILBRAY. Thank you. I am glad to hear we are not blamed for one thing.

Mr. HASH. I think that it's a function, in part, of the fact that the rates we pay plans are largely based on the experience in individual counties; and as you look across the country in terms of Medicare's expenditures, at a county level, they vary quite dramatically. And therefore, the rates that we pay the plans vary dramatically.

The BBA and the changes that were made in the payment policy are going to help to mitigate some of that variation and to narrow the range of payments across counties, but I think right now the variation is still significant.

Mr. BILBRAY. Well, if I'm not right, and I guess I would have to call on my colleague from California, I think part of this payment issue is that California did get less than what historically had been identified. But that aside, there is this issue of those plans that have dropped out. HCFA says right now there is a 5-year moratorium on them being able to participate, isn't there.

Mr. HASH. As a managed care plan—I'm sorry, as a Medicare+Choice plan, which they are not yet that, but if as a Medicare+Choice plan, they withdrew, they would not be able to enter that market for 5 years.

Mr. BILBRAY. We are looking at the expiration of the 1876 law. How does that affect the Medicare+Choice 5 year ban?

Mr. HASH. I think our view on that is that when someone signs a contract as a Medicare+Choice plan, then they are bound by the BBA requirement that if they were to terminate, that they would have a 5-year ban.

Mr. BILBRAY. Thank you. Mr. Chairman, I yield back my time.

Mr. UPTON. Thank you. The gentleman from California, Mr. Waxman.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

Mr. Hash, we are finding ourselves with an issue that is coming right now at the last minute, it seems to me. And I am trying to understand why we are being faced with this problem where managed care plans are saying to us, either all of us have to make ad-

justments or they are going to drop out. That's not just unique to California; it's all over the country.

One of the reasons we are in a hearing for this is that they had to file their ACR's on May 1, and they now say their situation has changed so much that they can't live with their submissions. Another is that HCFA's regulation imposed extra burdens whose costs they did not take into account.

Of course, you've responded to many of these comments they've made concerning the regulation, and in any case, it's been available for a long time. And in fact, the trends in health care costs have also been apparent for some time.

I am puzzled why we have this sudden frantic request to let managed care plans adjust their ACR's, change benefits and premiums, all at the eleventh hour. I know you've commented on it in your testimony, but could you elaborate on it for us. Why is this happening so late, in your opinion?

Mr. HASH. Mr. Waxman, we, too, don't have a good explanation for why these issues of adjusting the rates have only come up in the last 2 weeks. I assume that as plans got to the point where a decision was required with regard to giving us notice if they were going to be leaving participation in the Medicare program, that they had to give us notice by today, that they were coming up on their final decisions and presumably were making decisions that the expectation in terms of payment rates and other issues were causing them to not want to make that decision without asking us for the opportunity to adjust their filings.

As I said in the testimony, after reviewing those requests and analyzing the reasons that were being presented for these changes, we did not find that they were convincing and we did not find that it would be in the best interest of our beneficiaries.

Mr. WAXMAN. Well, the whole idea of choice is that beneficiaries will have information and then they can make a decision that will be an informed choice between different options that are being presented to them.

If we have this kind of a problem so late where beneficiaries aren't going to get the information they need because the decisions aren't being made till the eleventh hour, what does that say about the choice we are giving people? The obvious answer is it's going to be very confusing for beneficiaries to make those informed choices that we expect of them.

Is this a problem that's unique to the startup or is this endemic in some way in these Medicare plans?

Mr. HASH. I think that's a very important question. We are hopeful that this is a startup problem. But obviously, we need to work with the industry and others to figure out whether we are going to be right back in this same position a year from now, because we don't want to be there.

Because as you point out, coming up in November, beneficiaries will be receiving information from us and from health plans about the choices that are available to them. Because of these recent withdrawals, some of that information, at least in the printed form, is not going to be correct. So we are going to be, and are taking steps, to find other ways to get corrected information out to beneficiaries by this November so that they actually know what the pre-

miums might be, what the benefits might be, of plans that are serving their areas.

It's going to be a major undertaking for us to be sure that we have that information in a timely manner in front of the beneficiaries. And if this is going to be a recurrent problem, then we are going to have to find a way to eliminate this kind of problem at the last minute, because we will not be able to provide the information that beneficiaries will need to make the best choice for themselves.

Mr. WAXMAN. What troubles me is that, while we are having a startup issue with the whole Medicare+Choice program, we have had these 1876 risk contracts for some time now. Have we had this kind of problem in the past with these risk contracts, or is this all being presented to us this year in a unique way?

Mr. HASH. It has not been a problem, to my knowledge, in the past. I think, in fairness, this is a new program, the Medicare+Choice program. There are new requirements. There is a new payment system. And I think plans, like us, are having a quick opportunity to adjust to the range of changes that they are facing. But again, we have to hope that this was related to the startup of a new program.

Mr. WAXMAN. Let me just conclude by reading the last paragraph of Jane Bryant Quinn's article in Newsweek. "Older people weren't demanding Medicare options. Congress dreamed them up and owes you a total immersion course on how to choose. Until then, be smart. Keep the Medicare plan you have." That's what Jane Bryant Quinn is advising Medicare beneficiaries, and it sounds like good advice to me.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Upton.

Mr. UPTON. Thank you, Mr. Chairman.

Mr. Hash, again, we appreciate your attendance today. The big concern that I have had all along, particularly as I look at my district and the number of counties that I have and the difference in the rates, and of course, as it pertains to the options then that are available to the folks that I represent.

It is my understanding that HCFA could have increased those payments in counties, the AAPCC payments in counties with relatively low rates, had there been funds available to implement the blended rate of 90 percent national and 10 percent local.

And the Balanced Budget Act required that all payments be increased by at least 2 percent first, meaning that in plans where they were already receiving overpayments, that those were going to go out the door at the same time that those payments were going to go into those counties that were under the average.

Is that a fair assessment of what is going on?

Mr. HASH. Mr. Upton, I might phrase it just slightly differently than you did. I would say that in implementing the statutory language on the payment system, we had no choice, really, no discretion with regard to how we did that, because the Balanced Budget Act was quite explicit about how the new payment system would be put into place.

The result of that explicitness in the statute was that the blended payments, which were really targeted to the kinds of counties

I think you are talking about, did not come into play because once we provided the minimum floor payment, $367, plus the required 2 percent minimum update, and then applied budget neutrality, there was no money left to provide higher payments as a result of the blend.

We now believe the blend will start to be affected in counties that are qualified for the blend beginning in the year 2000.

Mr. UPTON. See, I would have like to have flipped them. I would have liked to have done the 90, 10, and then the 2 percent and maybe held the 2 percent off for those counties that were over the average. I am glad my chairman from Florida returned, but I was prepared to say that with him not in the room, as well. But to have done that would have required another legislative fix. You weren't able to do that.

Mr. HASH. That is correct, Mr. Upton.

Mr. UPTON. Okay. I yield back the balance of my time. Thank you.

Mr. BILIRAKIS. I thank the gentleman. Ms. Furse, to inquire.

Ms. FURSE. Thank you.

Mr. Hash, I just wanted to ask you a little bit about this Medicare+Choice education effort. We, in Oregon, were approached by HCFA to put together a proposal and to work together on making that happen. And we did that, and spent about $20,000.

Now, I have received a letter, and basically, what I am hearing is that the State of Oregon was told by HCFA that they didn't know how much money would be available, but in good faith, the State—and I am quoting from the letter—responded to the request and we formed a statewide steering committee and began the process of the educational rollout program.

Late in August, we were informed that ProWest from Seattle was awarded the contract for the educational portion of Medicare+Choice and the money they were awarded was to be shared with five States with a priority on rural and Pan-Asian communities. This surprising information meant that Oregon, after having been approached by HCFA to be a partner, would not receive any direct funding from HCFA to carry out our mission.

The letter goes on to say, "We will still move ahead with our plan and train the trainers and beneficiary seminars, media coverage, and we will do so primarily independent of HCFA," and that ends the quote. I want to raise this question to you. First of all, why weren't the funds given directly to the States or agencies that had actually designed and were implementing a rollout program?

Mr. HASH. My understanding of that work between our regional offices and the States, like yours, is that we primarily used the money that we had available for these kinds of activities to develop materials that could be used to explain and assist our beneficiaries, and to use the connections and network that States and their partners would have in order to extend our reach to beneficiaries with this information.

The limited amount of money that we had for this purpose we have put into two things, as I understand it. One is the production of materials, some of which are in other languages. In the case you referred to, I think that is for the translation of our Medicare information materials into several Chinese dialects.

And the second purpose of our expenditures, I think was to put some extra money into the grants that we make to State and local counseling agencies, the so-called State health insurance programs, which we have been funding in the past, but because of the Medicare+Choice outreach efforts, we have expanded the resources there. And that's been where the bulk of the money has gone.

And I should mention a third thing that you referred to. We have been supporting conferences for the purpose of training trainers who would then be qualified to give advice and counsel to beneficiaries about this new program.

Ms. FURSE. But is it your understanding that these States were led to believe that they would receive financial assistance from HCFA to cover these costs?

Mr. HASH. I am not familiar with the specifics of the case you mention, but I am happy to tell you I will look into it and we will provide you a full explanation of that.

[The following was received for the record:]

I am sorry for any confusion on whether States would directly receive funding. An appropriation of only $95 million, even though $200 million was authorized, required a more limited approach for our education efforts. We regret any misunderstandings. We are implementing a range of other education activities in Oregon. We are meeting with State partners, conducting train-the-trainer courses, briefing Congressional district office staff, and participating in AARP forums. In addition, every State Health Insurance Assistance (SHIP) program, including Oregon's, is receiving supplemental funding for the education efforts.

Ms. FURSE. Well, I would really appreciate that. I have to tell you, Oregon will go ahead and do the right thing; we will continue with the project. But as you can imagine, with all that planning and the kind of money that Oregon has now spent, we would like to know what kind of process there is and how that process came about. I would really appreciate your response.

Mr. HASH. And I would also like to take this opportunity to say that we were not at all satisfied that we had adequate resources to do this job, either. These resources are drawn, as you may know, from the authority in the Balanced Budget Act for health plans to provide payments for the Medicare education project. For this year, Congress allocated $95 million for that purpose.

Almost all of those funds went for two things: the production of handbooks and other informational materials to go to beneficiaries, and the support for a 1-800 toll free information line with customer service representatives available. So there was very little money left out of that to support what's a critical piece of this, which is the outreach through partners at the State and local level, to reach beneficiaries on an individual basis.

Ms. FURSE. Thank you. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentlelady. Mr. Burr, to inquire.

Mr. BURR. Thank you, Mr. Chairman.

Welcome, Mr. Hash. Let me give you a scenario real quick. I am a Medicare beneficiary; I am a patient. December 29 of this year, I have severe chest pains. I am on what is currently an HMO risk contract. My provider has chosen not to, for whatever reason, participate in HMO choice plus. I go in and it's determined that I have to have bypass surgery and I'm going to have an extensive 7-day stay or 5-day stay in the hospital. Who's going to pay for it?

Mr. HASH. Well, there is no question that that individual is a Medicare beneficiary, and they will be fully covered to the extent of Medicare benefits for that hospital episode and the related care for that condition.

Mr. BURR. Who's paying it?

Mr. HASH. Who will pay?

Mr. BURR. Who will pay?

Mr. HASH. It will actually be the result of a choice that the beneficiary will have made. If you are saying the hospitalization and the event occurs while they are still covered by the plan?

Mr. BURR. Well, on the 29th, they are still covered by the old plan, because there is no Medicare+Choice until January 1.

Mr. HASH. The plan would be responsible.

Mr. BURR. The plan they are currently under.

Mr. HASH. That's my understanding.

Mr. BURR. Now, they're going to be operated on and hospitalized in January. They are hospitalized on the 29th, the operation took place on the 30th, they are still in the hospital on the lst, 2nd, through the 5th.

Mr. HASH. The plan is responsible until the completion of that episode for the cost that the beneficiary incurs.

Mr. BURR. In this particular case, there is a rehabilitation that goes along with it from home health. That could run up to 100 days. Who accepts that? Who pays it?

Mr. HASH. I think once that hospitalization episode ended, then of course, the person would now be outside the responsibility of the plan they had been formerly a member of; and then it would either be the traditional Medicare program, if that's the option that was available to them, or if they had enrolled in another Medicare managed care plan that served their area, that plan would be responsible.

Mr. BURR. Could that HMO risk contract have used the services of a physician that is not recognized by Medicare fee-for-service? In other words, somebody that doesn't service patients on Medicare fee-for-service?

Mr. HASH. Well, if a practitioner has formally opted out of the Medicare program, they would not be eligible to receive payment, either directly or indirectly from a managed care plan.

Mr. BURR. So, in this particular case, if that's who they saw because there was a relationship between the risk contract HMO, but that individual was not participating in fee-for-service, the patient would actually have to switch physicians then.

Mr. HASH. The practitioner who had opted out would not have previously been able, if they had opted out at that point, they couldn't have served the patient in the previous managed care plan either.

Mr. BURR. Couldn't have been contracted with the HMO, even though the didn't contract with fee-for-service.

Mr. HASH. Not for the Medicare.

Mr. BURR. Okay, I will buy that one. Let me ask you, when does HCFA plan to notify patients if their plan has chosen not to move to Medicare+Choice?

Mr. HASH. We are in the process right now of taking all the actions we can, in fact, to get the word out. Obviously, we share that

responsibility with the plans themselves. They have an obligation to notify all of their enrollees within 60 days of the termination of their agreement.

Mr. BURR. I would take for granted that much of the decision HMO's will make is based upon the regulation that you set, the QISMC. I know you just got that straight yesterday and updated it on your website. There are other things that I believe, still today, are holes in the reg, though, aren't they?

Mr. HASH. I believe we have indicated publicly this week a number of areas in the regulation where we have provided additional interpretation, where we have provided a recognition of a phase-in or a transitional period for compliance with the requirements. I'd be happy to give you a list of all of those. But I think we have been very responsive to the issues that have been raised to us by the plans.

I might say to you, some people have indicated in a generic sense that they have problems with our requirements in the reg, and think that they may result in higher costs, but have not actually specified what those specific burdens are.

For organizations who have come to us and given us a specific list of things that they would like some assistance with, we have tried to be very responsive.

Mr. BURR. Mr. Chairman, could I ask unanimous consent of my colleagues for 3 additional minutes to finish so that I can return to a hearing upstairs, because I won't be able to come back down?

Mr. BILIRAKIS. This chairman will not object, but I am concerned that we have two additional panels and a number of panelists. Without objection, the gentleman has 3 additional minutes.

Mr. BURR. I would thank the chairman and say this is a very important issue.

In the legislation, HCFA is required to approve any of the materials that HMO Plus Choice companies use. Have you, in fact, approved any of the brochure material yet for any company?

Mr. HASH. I can't give you specifics right here, but in general, I can say yes, we have. The procedure, as you may know, is they are required to submit to us for a period of 45 days their proposed marketing materials. If we do not disapprove them within a 45-day period, they are automatically——

Mr. BURR. So for a company that makes the decision by 12 o'clock tonight, 2 o'clock, whatever it is tonight, to participate, and they send you the information, you've got 45 days to approve it. The likelihood is that for those individuals who are searching a new HMO product because their other one chose not to be a Plus Choice participant, at some point, they are going to get a packet about this thick with an application and information about the plan and be expected to sign an application and fill it out by the end of November or HCFA will automatically put them on fee-for-service. Is that my correct understanding?

Mr. HASH. I think the answer is that the plans who would now be making that decision are plans who have anticipated participating in Medicare at least since the——

Mr. BURR. But they are going to wait 45 days for you to approve this, right?

Mr. HASH. If someone has not submitted their material as of now, it would be a 45-day period. And all of the plans who are now making announcements are plans who told us on May 1 that they were participating, so that I would presume they would have sent us their marketing materials early in the summer and that 45-day period would be passed.

Mr. BURR. Well, we'll certainly have an opportunity to ask some of the industry folks whether that's a problem. Let me follow up on Congressman Bilbray's question about the intended use of the so-called 5-year lockout.

Just so I understand your position, if an 1876 contractor declines to join Medicare+Choice program, is there anything in the statute that prevents that plan from entering the Medicare+Choice program at any time within 5 years of its departure from the 1876 program?

Mr. HASH. Our position is that any plan may enter the Medicare+Choice program initially at any time they choose.

Mr. BURR. If a plan went in today, before the deadline, but once rules were clarified somewhat and they dropped out, let's say in November of this year, would you see that as an automatic 5-year exclusion from participation?

Mr. HASH. We don't actually have anyone now in a Medicare+Choice contract. Those contracts are going to be effective on January 1.

Mr. BURR. So let me just make sure I understand you—and this is my last question. If a plan said today, we want to be a Medicare+Choice contractor, and 30 days from now, they choose to pull out of it. And 6 months from now, they decide to reenter it, HCFA will not say, no, there's a 5-year exclusion.

Mr. HASH. No, let me be clear about that. If they sign a contract with us now as a Medicare+Choice contractor, and a month from now, or 2 months from now, or 10 months from now, they decide to leave the Medicare+Choice program, they could not reenter for 5 years.

Mr. BURR. Now, this is very important.

Mr. BILIRAKIS. The last question.

Mr. BURR. Yes, sir. This is a very important timeframe. There is not a Medicare+Choice plan until January 1.

Mr. HASH. Well, let me say on that point, I know we have a number of applications pending right now for new plans who would be coming in as Medicare+Choice plans. I do not believe any of those contracts have been executed as of today.

Mr. BURR. If they dropped out before——

Mr. HASH. But if they execute the contract and it's effective and they drop out, then they would be dropping out of a Medicare+Choice contract and therefore would be subject to the statutory 5-year ban.

Mr. BURR. Even in this 2 or 3 month period where there is no—we haven't even hit the enactment date of the plan.

Mr. HASH. Well, no——

Mr. BILIRAKIS. The gentleman's time has long expired. We've got to cut it off somewhere, with all due respect, Richard.

Mr. BURR. I thank the chairman.

Mr. BILIRAKIS. Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman.

Mr. Hash, I want to talk to you about a couple of components of what we were trying to do when we passed the bill in the budget agreement. The first thing we were trying to do is to provide more options for beneficiaries, and that's why we tried to give folks the option of enrolling with a PPO.

Now, it's my understanding that HCFA has received only one application to provide a PPO product. Do you have any sense why this might be the case?

Mr. HASH. I think the evidence that I have from talking with representatives of plans of those types of models were concerns regarding a number of our requirements, particularly in the quality improvement area, given the nature and structure of more loosely organized networks of health care plans.

I think what we have done in our recent reissuance of the quality improvement system for managed care is that we have spoken to many of those concerns, and I believe that what we have laid out now has allayed the apprehensions of many PPO's and that we will see an increase in interest on their part.

Ms. DEGETTE. So you think the cost was the factor, or the quality?

Mr. HASH. I think some of the requirements for quality improvement projects, for data reporting on quality activity, for actually meeting performance standards in relation to quality measures, were concerns. Open-ended or more loosely organized networks of providers, such as PPO's, were concerned whether they could actually have the ability to achieve those kinds of expectations.

And I think in working with them and in revising the QISMC, the Quality Improvement System for Managed Care document, I think we addressed many of their concerns.

Ms. DEGETTE. So you don't think it really has to do with the PPO's perception that it would be difficult because of their loose organization for them to control payment rates. You don't think they've got a problem with the payment structure?

Mr. HASH. I can't speak to that issue, but I think if they have an issue around payment policy, it would not likely be different than any kind of managed care plan in looking at the Medicare payment system.

I know of no reason why the payment system itself would be a unique issue for PPO's.

Ms. DEGETTE. We have been researching what private sector purchasers are doing in terms of the requirements for their health plans. And I have received a number of documents from some of these private purchasers. I've got one here from General Motors, for example, which tells their Medicare HMO's that they expect the plan to have an established procedure to conduct a geriatric health profile upon enrollment.

I've got another one from Digital Corporation which talks about a requirement that the HMO administer and report the results of the NCQA annual member health care survey as specified in the most recent version of HEDIS. And it also specifies that the average speed of answer to a member service representative nonrecorded voice shall not exceed 30 seconds.

It also requires the HMO to maintain a defined program to systematically evaluate the performance of all participating providers, including cost and performance measurements, clinical service performance measurements, integration of provider information, and you get the drift.

It seems like the private sector has some very, very tough standards. What I'm wondering is if HCFA intends to hold the health plans that contract with Medicare to those same standards, and I would hope that would be the case for our beneficiaries?

Mr. HASH. The full and complete answer to that is yes. And in fact, I won't even elaborate because you have articulated it better than I could, that we are trying to, in effect, model our expectations in this area from those that have been put forward by large purchasers of health benefits, particularly employers.

Ms. DEGETTE. Great. Thank you. Mr. Chairman, I will yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentlelady. I understand the thought has been uttered for a second round. The Chair is not inclined to go a second round. If the gentleman from Iowa wishes unanimous request for additional time——

Mr. GANSKE. Mr. Chairman, I know you want to move on. If I could ask for a unanimous consent for 2 additional minutes.

Mr. BILIRAKIS. Without objection.

Mr. GANSKE. Thank you.

Mr. Hash, it is my understanding that HCFA may use the risk adjustment system to reduce health plan payments by as much as 7 percent. To me, that sounds reasonable since that is an approximation of the amount Medicare HMO's have been overpaid because of their favorable selection.

I know that some of the witnesses on the next panel may be urging HCFA to implement a budget neutral risk adjuster. Mr. Hash, wouldn't that prevent the risk adjustors from doing their main job, i.e., correcting the overpayments that have resulted from favorable selection.

Mr. HASH. Mr. Ganske, we believe the risk adjustment should be related to the individual enrollee, and therefore, it would not necessarily be budget neutral to the plan or plan neutral, as it were. So we do think that the most appropriate way of adjusting payments for risk is to do it on an individual basis, and that's what our intention is.

Mr. GANSKE. On the next panel, Mr. Hash, I think we will hear complaints that the complex AAPCC formula, which moved many of my counties to a national floor, failed because there was not enough money this year to fund the blend that was supposed to close the gap between the high and the low counties.

Can you tell me how much Medicare would have to spend to fully fund the blend this year?

Mr. HASH. I am informed that the estimate is if we fully funded the blend this year, or next year in 1999, it would be about $300 million.

Mr. GANSKE. Three hundred million.

Mr. HASH. That's correct.

Mr. GANSKE. Thank you, Mr. Hash, and I yield back, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Administrator, thank you so much for your patience and for coming to see us again. We valued you as a committee staffer, and frankly, we value you as Deputy Administrator of HCFA. Thank you very much.

Mr. HASH. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The next panel. Ms. Patricia Riley, Vice President, Government Relations, Allina Health Systems, Minneapolis, Minnesota; accompanied by Ms. Karen Ignagni, President and CEO of American Association of Health Plans; Mr. Bill Gradison, President of Health Insurance Association of America; Mr. Bruce Bradley, Director of Managed Care Plans, General Motors Corporation of Detroit, Michigan.

And I will yield to the gentlelady from Oregon to introduce the additional panelists. If we can have order, please.

Ms. FURSE. Thank you, Mr. Chairman, very much.

Mr. BILIRAKIS. If we can have order, please.

Ms. FURSE. Mr. Chairman, I am very pleased to introduce Mr. Don Sacco. Mr. Sacco is President and Chief Executive Officer of Regence Blue Cross and Blue Shield of Oregon, and the largest health benefits company in my state.

Mr. Sacco is from Lake Oswego, which is in my district, and he has worked with me on promoting the concept of kids only health insurance.

Recently, we held an event in Oregon with Blue Cross and a number of organizations on the kids only issue, and he has been a leader in this. Mr. Sacco has had a distinguished career in health administration and I want to welcome him to the subcommittee on health. And I thank you, Mr. Chairman, for the honor of introducing him.

Mr. BILIRAKIS. You are very welcome. And Mr. Sacco is accompanied, as I understand it, by Ms. Mary Nell Lehnhard, Senior Vice President of Blue Cross Blue Shield Association.

Mr. Brown.

Mr. BROWN. Mr. Chairman, I am sorry to interrupt with this. I just wanted to ask unanimous consent for an article in the National Journal, called "Medicare's Exodus," to be entered into the record.

Mr. BILIRAKIS. Without objection.

[The information referred to follows:]

Medicare's Exodus

CONGRESS WANTS MORE OF THE ELDERLY IN HMOS, BUT MANY HMOS DON'T WANT MORE ELDERLY. THEY SAY THEY CAN'T AFFORD TO PROVIDE BENEFITS, AND ARE CALLING IT QUITS.

BY MARILYN WERBER SERAFINI

When Congress passed last year's balanced budget act, elderly Americans were promised an array of new, appealing choices in Medicare. The new program, called Medicare+ Choice, was championed by Republicans as a way to end the government-knows-best mindset of the 33-year-old insurance program and to let beneficiaries pick what type of health plan best suited their needs.

ANTHONY HUBSHER

If they wanted, older Americans could, for instance, join health maintenance organizations or other managed care plans, pay fewer out-of-pocket expenses and get extra benefits, such as coverage for prescription drugs, eye glasses and dental visits.

But serious problems are threatening that promise. Faced with high costs, lower-than-expected profits and administrative headaches, health care companies are starting to pull their Medicare HMOs out of many markets or cut back on benefits and raise prices. As many as 350,000 Medicare recipients will be kicked out of their HMOs next year, according to Clinton administration estimates, and at least 50,000 of them may have no other HMO to choose from.

"It's most alarming where there are terminations and no other plan is available," said John C. Rother, director of legislation for the American Association of Retired Persons, the powerful Washington-based lobby for the elderly. "There are people really hurting because they have no access to prescription drug benefits and there are higher costs. This is something Congress didn't anticipate."

Just ask Lolo and Otto Heitlinger. At ages 78 and 88, respectively, they are no strangers to hardship. After surviving the Holocaust in Germany, they ended up in Wilmington, Del., where they raised a family and worked in the jewelry business well past the age when most people retire.

Now, the couple says it can't find a Medicare health plan that they can afford or that's willing to stay in New Castle County. The Heitlingers have been through three HMOs since 1996, when they signed up for Medicare, the government's health insurance program for the elderly. Two HMOs shut down, and the third cut back benefits to the point where the Heitlingers said they were worried about the effects on their health.

Theoretically, they could opt for fee-for-service Medicare—the traditional program that allows patients to go to the physician of their choice and pay a portion of most bills. But the Heitlingers say that's not realistic. "We can't go to [fee-for-service] Medicare because it doesn't pay for pharmaceuticals. How can we afford that?" asked Lolo Heitlinger, who says she must take drugs for high blood pressure, asthma, and estrogen replacement. All that prescription medication costs nearly $200 a month. "Imagine monthly to lay that out," she said. "It's horrible. It really is."

The Heitlingers could buy supplemental insurance, called Medigap, which many Medicare recipients purchase to cover drugs and other out-of-pocket costs. But they say the policies available to them would cost $220 per person per month. Plus, she said, "they gave me a hard time because I'm a cancer survivor. I would have to wait six months before I could be an active member. I need a mammogram every nine

ROCKY START: Otto and Lolo Heitlinger (top) worry about HMOs. A HCFA official briefs New Jersey seniors on new Medicare options.

months. I see an oncologist every six months."

Some leading congressional Republicans—especially those responsible for last year's changes—say it's too soon to tell whether the troubles reported by the Heitlingers and other elderly Americans reflect major problems with Medicare HMOs or are simply the inevitable complications that always accompany new ways of doing things.

Rep. William M. Thomas, R-Calif., administrative chairman of the bipartisan Medicare commission, which was established this year to look at Medicare's long-term problems, and chairman of the House Ways and Means Health Subcommittee, says he'll wait to see the extent of the HMO pullouts before pushing the panic button.

Republican policy-makers have a big stake in the outcome. They assumed that making HMOs more attractive to Medicare beneficiaries would help control costs and extend the solvency of the financially ailing program. The Balanced Budget Act of 1997—which, besides making more health plan choices available to the elderly, also made it easier for doctors and hospitals to own and operate managed care plans—projected that 25 percent of Medicare recipients would be enrolled in managed care plans within the next few years. Thus far, Medicare HMOs have wooed 17 percent of the elderly (6 million) away from traditional fee-for-service plans.

For their part, health plan executives say they need higher reimbursements from the government to be able to operate HMOs in certain parts of the country, such as rural areas. And they want assurances that the Health and Human Services Department's Health Care Financing Administration, which oversees Medicare, will allow them to cut back on benefits and raise prices for Medicare patients.

Laying Blame

Many congressional Democrats have long had their doubts about Republican plans for shifting Medicare recipients into managed care. Now that Medicare HMOs are faltering, they say their fears were justified—and predict Republicans will have to swallow hard and seek more money for Medicare.

"Voters are going to get very mad" when they have to leave their HMOs, warned Fortney H. "Pete" Stark of California, the ranking Democrat on the House Ways and Means Health Subcommittee.

James A. McDermott, D-Wash., a Ways and Means member who also sits on the bipartisan Medicare commission, called the situation "cataclysmic." In 1995, when Republicans took control of the House and Senate, "Congress changed religions to the church of the free market," he said. "Republicans promised miracles and all kinds of wonderful things that cost nothing or less. And people flocked into those churches. But it was a limited success, if not an out-and-out fraud," he said, laughing the I-told-you-so laugh.

"Congress was trying to change the health behavior of 35 million people in one year," McDermott continued. "If Republicans ask for more money, we're going to see the [budget] surplus go up in smoke. They made all the cuts in Medicare, and now they're going to have to throw more money at [the health plans]."

"It's kind of a poorly thought-out idea to go on the premise that anything that's profit driven and market driven is better than anything else," Stark said. "It's similar to saying the only laws the country needs are the Ten Commandments. It doesn't really deal with parking meters."

Part of the problem, critics claim, is that HMOs are paying their executives too much money. A recent study by Fami-

JAMES MCDERMOTT: "Republicans promised miracles and all kinds of wonderful things that cost nothing or less."

lies USA, a Washington-based consumer health watchdog group, concluded that top HMO executives in the nation's largest for-profit managed care companies took home, on average, $2 million apiece in 1997. "The whole rush by Congress to get everyone out of fee-for-service and into managed care is meeting the reality that [the health plans are] in it to make money," McDermott said.

Members of Congress who represent states where HMOs are cutting back are starting to scramble. The home state of Republican William V. Roth Jr., chairman of the Senate Finance Committee, includes Wilmington, where the Heidlingers and nearly 8,000 older Americans will lose their health coverage with Aetna U.S. Healthcare at the end of this year. "I've had a number of calls and obviously I'm concerned," Roth said, adding that his committee will hold oversight hearings next year. In a Sept. 23 letter, Roth urged HCFA Administrator Nancy-Ann Min DeParle to see if there are any "administrative adjustments within your power that could be made now to deter further plan exits."

Charles E. Grassley, R-Iowa, who heads the Senate Special Committee on Aging, is particularly concerned about rural areas. "One of the major benefits to rural seniors is down the drain if they can't get access to HMOs," he said. Several Ohio members of Congress are taking an even more active role. Sen. Mike DeWine and Rep. David L. Hobson, both Republicans, as well as other delegation members, sprang into action when Anthem Blue Cross and Blue Shield announced recently that it would shut down its Ohio operations, dropping more than 12,000 people from its rolls. Those in six counties, including Greene County, DeWine's home, would have no option but to go back to Medicare fee-for-service.

DeWine blames the company. "Anthem was successful and sophisticated in selling its program. It got people to switch, and now they turn around and tell the people they're sorry. They told the people, 'We'll be around as long as Medicare is.' Anthem really messed up. Big-time."

Inundated with complaints from constituents, the Ohio delegation, Republican Gov. George V. Voinovich and other politicians asked Anthem to reconsider. Negotiations are ongoing between the politicians, the company and HCFA, and an agreement may be near. It appears that Anthem may stay in six of the Ohio counties. But executives say they will have to cancel some benefits or raise prices or take both steps.

HMO QUANDARY

To what extent are Anthem and the other HMO companies to blame? Barely at all, according to industry executives. They say their firms can't survive on the low payment rates in many counties—rates set by the federal government.

"Anthem was attacked by Mike DeWine because it's leaving seniors in the lurch," said Susan Bartlett Foote, president of Public Policy Partners, a Washington-based consulting firm that's coordinating a coalition to try to alter the Medicare payment system. "But he has no real understanding. It's not necessarily a bad company. They're looking at what they're going to be paid, and in some areas they just can't make it."

Health plan executives are complaining that it will be both expensive and difficult to comply with HCFA regulations that resulted from the balanced budget act. The Blue Cross and Blue Shield Association, which represents 54 independent Blue Cross and Blue Shield Plans, has asked HCFA to delay the start date of a number of rules and to reconsider others. Joel Slackman, director of policy analysis at the association, complains that HCFA strayed from the intent of Congress in devising many of the rules.

For example, Slackman complained that the agency places too great a burden on health plans to consider

MEDICARE HMOS PACKING UP

Medicare HMOs are beginning to pull out of counties where they're losing money. HHS estimates that by the beginning of next year, 350,000 older Americans may lose their HMOs. Here are the health plans that had announced departures as of Sept. 30, 1998:

HEALTH PLAN	PEOPLE BEING DROPPED
AETNA U.S. HEALTHCARE (INCLUDES NYLCARE) (CT, DC, DE, FL, MA, MD, NH, RI, VA)	78,000
ANTHEM BLUE CROSS AND BLUE SHIELD (OH)	11,500
PRUDENTIAL HEALTHCARE (CA, DC, FL, MD, RI, NY)	25,000
HUMANA INC. (FL)	34,000
INTERMOUNTAIN HEALTH CARE (UT)	7,000
MDIPA (MD)	11,000
FOUNDATION HEALTH SYSTEMS INC. (CA, CT, NJ)	15,800
PACIFICARE HEALTH SYSTEMS (UT)	78,000
ALLINA HEALTH SYSTEM (MN)	10,000
TOTAL	202,100

SOURCE: INDIVIDUAL COMPANIES

appeals from doctors who haven't been allowed to participate in a plan. "We sometimes get dozens of requests a day from doctors who want to participate," said Slackman. He also cited a rule that requires health plans to assess the medical condition of each new enrollee within 90 days. Plans already conduct health "screenings"; an "assessment conjures something more extensive, but HCFA doesn't say what they want."

Moreover, the agency is developing a system to pay health plans based on the hospital stays of patients in a given plan. Slackman says he's worried that the most efficient plans with the fewest hospitalizations will end up with the lowest payments, even if they're incurring extra costs by substituting home health care, preventive care and other services.

Compliance with the new rules will be costly, according to Karen M. Ignagni, president of the American Association of Health Plans, the Washington-based group that represents most HMOs. "There are extraordinary burdens for data collection," she said. "We have to give cost data, accounting data, encounter data with providers, we have to extract information from provider files." Further, she said that doctors are so angry about their reporting responsibilities that some are saying they want to do business just with fee-for-service Medicare and not with HMOs.

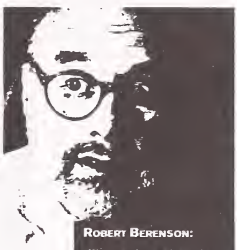
Moreover, health plans are nervous about the threat of penalties, which range from fines to withholding payments or even loss of Medicare contract, says Blue Cross and Blue Shield's Slackman. Robert A. Berenson, director of HCFA's center for health plans and providers, is telling HMO executives not to worry, that he'll be flexible in giving them time to comply with the rules. But Slackman worries that the decision may not be Berenson's, if the Justice Department becomes aggressive in enforcing the False Claims Act, which authorizes it to take action against health plans that don't meet federal regulations. "Lots of plans are thinking hard about the business wisdom of their participation [in Medicare]," Slackman said. "When plans look at the climate of uncertainty, and the climate of payments being uncertain, it doesn't speak positively."

Susan Bartlett Foote:
"We're seeing choices and extra benefits in those areas that HMOs have decided are lucrative."

Show Me the Money

Low payment rates in many counties may be driving many businesses to rethink their Medicare participation. As part of the balanced budget act, Congress attempted to make the payment system fairer by raising the rates in low-payment counties and lowering the rates in the best-paid counties. But pressure from representatives of counties facing reductions made it difficult to do more than tinker around the edges. And there hasn't been enough money in the federal budget to raise the rates as much as some had hoped.

Consider Anthem. It introduced Anthem Senior Advantage in Cincinnati in 1994. Its payments from Medicare weren't the highest in the state, or the lowest. But based on its success in Cincinnati, Anthem expanded its services to elderly residents of other Ohio counties in 1996. Although Anthem wanted to expand only into areas in which the payment rates were appealing, and where there were sufficient providers available, it ended up also serving some less-attractive counties to avoid running afoul of government regulations. The result was an increase of 17,000 members, to about 58,000. Anthem was touted as one of the fastest-growing HMOs in the country.



Robert Berenson:
"We can't make plans stay in an area where they have the contractual right to leave."

While fast growth may be good in many businesses, it's not considered sound for health care delivery. "Our infrastructure was struggling to support [the growth]," said Lynne Gross, Anthem's vice president of government products. She complained that it was difficult to determine whether revenue from the government would be sufficient to pay claims. This year, Anthem determined that it had grown bigger than anticipated in the rural areas, where reimbursements are usually low and where the medical infrastructure is insufficient to support a managed care program.

Rural areas have fewer doctors and other health care providers, not to mention organized provider groups. "There was no home health care agency to go to the rural areas to implement our congestive heart failure program," Gross said. To get an agency to visit older patients in those areas, Anthem had to pay a premium on top of the contract rate, "and it was costing too much."

Traditional Medicare simply had not been meeting the needs of the elderly in the rural areas, she said. So when Anthem began offering a range of services, older patients jumped at them. The problem was that the federal government pays HMOs a set monthly fee for each patient. That's called capitation, and the fee is set at 95 percent of what an average fee-for-service participant in the area costs the government. Because Anthem took new services to rural areas and older patients used them, the capitation rate did not come close to covering Anthem's expenses, Gross said. "We overran our budget, in some areas tremendously, because of the pent-up need for care."

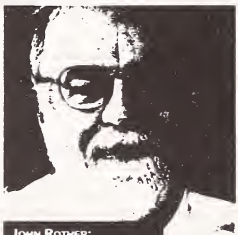
In addition to pulling out of the lowest-payment counties, many health plan executives intend to reduce benefits

or raise prices, or maybe take both steps. Medicare HMOs had to notify HCFA by May 1 if they planned to do so, and none did, Berenson said. But in the last few weeks, a number of plan executives have asked the agency to let them refile the notifications, he said, on the grounds that they can't survive without the ability to cut benefits and raise prices. "We can't make plans stay in an area where they have the contractual right to leave. They're concerned, and we're doing what we can to keep them," Berenson said.

Four Connecticut Democrats—Sens. Joseph I. Lieberman and Christopher J. Dodd, and Reps. Sam Gejdenson and James H. Maloney—have asked HCFA's DeParle to allow health plans to change their benefits and prices. "Since May, it has become increasingly clear that the trend in medical inflation is significantly higher than expected," they wrote.

DeParle, though, said it wouldn't be in the best interests of Medicare beneficiaries to "open up all the plans and let them offer less benefits and see costs go up." Berenson said the agency is trying to find a way to allow some of the executives to refile.

High prices for medication are also a major concern for HMOs. Prescription drugs are the "uncontrollable that's tipping the scales for some of these plans," said the AARP's Rother. "Those costs are way above what their expectations were. It's one of the major reasons the plans aren't making it." According to Rother, many new expensive drugs are being marketed directly to consumers. Said Stark: "They're coming directly to you and me telling me my sex life will be better, your hair won't fall out, and you won't sneeze."



JOHN ROTHER:

"If the plans as a result of financial trouble drop pharmaceutical benefits, people may not join."

Musical Chairs

While a number of plans are leaving Medicare, it should be noted that HCFA has applications pending for HMOs to create new plans in 45 service areas. "It's not fair to say everybody is dropping out of the program," Berenson said. However, he acknowledged, there is a significant gap developing between have and have-not areas.

"What we're getting is a two-tiered system," said Foote of Public Policy Partners. "We're seeing choices and extra benefits in those areas that HMOs have decided are lucrative."

That may discourage executives of new kinds of health plans from getting into the Medicare business, she said. Doctors and hospitals, for example, were expected to jump at the chance to own and operate their own systems, called provider-sponsored organizations. But they aren't. "Hospitals are being advised not to do this," said Foote. "The big HMOs already staked out the markets that are lucrative, and it's hard for a hospital to get in and compete in Los Angeles with Kaiser. The hope was that the PSOs would enter the markets the HMOs had neglected, and those are the markets where the payment rates are not as high. So the margin is not as good, and the risks are higher that they'll lose money."

Ellen A. Pryga, policy development director at the American Hospital Association, says that the expectation had been that 45 to 60 hospitals or physician groups would apply to start provider-sponsored organizations. There were only three such applications, and only one was approved by HCFA.

"There's a bit of retrenchment going on. People who were moving ahead full steam, planning to submit applications, have either decided not to or they are waiting for a few more things to sort out before determining whether they can proceed," Pryga said. Plus, she added, the fact that existing Medicare HMOs are waving caution flags is discouraging those thinking about getting in. "If the guys who have been doing it can't do it, we'd better go back and do our homework to make sure we can."

Take HealthSystem Minnesota, a hospital-based health system that now contracts with an HMO to offer a Medicare health plan in Minneapolis. It had hoped to become a PSO under the new law, but Minnesota's low payment rates, combined with market and regulatory uncertainty, have given executives pause. Mark Skubic, vice president for public policy and government relations, says the health plan may go back to serving the elderly under Medicare fee-for-service. Skubic said that the requirements to become a PSO are so stringent that HealthSystem Minnesota would have to set up a separate insurance structure—to become an HMO in essence.

Then there's the payment problem. Medicare payments in Minnesota are below HealthSystem's actual costs, he said. "We've been struggling as a care system, and we're getting to the point where we're just able to achieve a positive margin. Costs on Medicare are going up 10 percent per year, while payments are going up only 2 percent."

"The idea was to open up choices," said Foote. "That's the irony that Republicans haven't faced, their big Medicare+Choice, to make lots of options available to Medicare beneficiaries simply is not going to happen. No one's going to do MSAs (medical savings accounts), people are not moving into PSOs, HMOs are being aggressive in tailoring services only to the market areas that make money for them, and where they can offer extra benefits. Medicare+Choice is not going to exist for many people in America. What does that say for the great balanced budget act?"

The long-term challenge for Congress will be to find a better payment mechanism if it wants to stabilize Medicare+Choice. An advisory committee to Congress is in place, working on how to design competitive pricing, which the federal government employee health plan now uses.

But in the end, "we may not see as much of a range of options, certainly not in every community," said the AARP's Rother. "If the plans as a result of financial trouble drop pharmaceutical benefits, people may not join. Then [the health plans have] dropped the reason people enroll."

Whatever the response, Medicare will certainly be back in political play. "This is one of the real lobbying issues of next year," said a House Democratic aide. "Republicans have to decide whether Medicare is a way to provide extra new benefits for seniors or a way to save money. They're conflicted on that. They can't decide one way or the other." ■

Mr. BILIRAKIS. Ladies and gentlemen, as you know, your written statement is already a part of the record. The clock will be turned to 5 minutes. We would appreciate it if you could stay as close to 5 minutes as you possibly can for your oral comments. And we will kick it off with Ms. Riley.

STATEMENTS OF PATRICIA A. RILEY, VICE PRESIDENT, GOVERNMENT RELATIONS, ALLINA HEALTH SYSTEM; KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN ASSOCIATION OF HEALTH PLANS; BILL GRADISON, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA; DONALD P. SACCO, CHIEF EXECUTIVE OFFICER, BLUE CROSS BLUE SHIELD OF OREGON, ACCOMPANIED BY MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, BLUE CROSS BLUE SHIELD ASSOCIATION; AND BRUCE E. BRADLEY, DIRECTOR, MANAGED CARE PLANS, GENERAL MOTORS CORPORATION

Ms. RILEY. Mr. Chairman and members of the committee, my name is Patricia Riley, and I am Vice President of Government Programs at Allina. Allina Health System is operating in Minnesota and the upper Midwest. We are a charitable 501(c)(3) corporation comprised of hospitals, nursing homes, clinics, and managed care plans. Medica is a managed care plan owned by Allina. It is a nonprofit organization that is NCQA accredited and governed by a board that is made up of over 50 percent physicians.

Medica served over 70,000 seniors, 35,000 of which are on Medicare risk. We have been in the risk contract business for 15 years, and have one of the lowest disenrollment rates and highest satisfaction rates in the country. I just want to say that I very much enjoy my work, and I am very grateful for the opportunities I have had at Allina to be able to be innovative around the needs of the elderly population.

On Wednesday of this week, I had the unfortunate task of informing thousands of Minnesota seniors that they will no longer have Medica Medicare risk as an option in four counties. Many thousands more will not be able to stay on the risk product because their doctors and hospitals can no longer afford to provide Medicare services with the inadequate capitation rate from Medicare.

In 1997, the Congress passed the Balanced Budget Act, creating the Medicare+Choice program. Members of this committee made significant contributions to this historic legislation. I want to focus my oral comments to two critical messages. The BBA set out to accomplish two things: No. 1, to create a payment formula which would reduce geographic inequity; and No. 2, to create a Medicare program which was accessible and predictable for seniors.

We were optimistic that the BBA would accomplish these goals with a floor, a blend, and a minimum update. Unfortunately, the blend wasn't funded in 1998 or 1999. As a result of the blend not occurring and the instability of future risk adjusted payments, seniors may see fewer choices, more expensive coverage, no fix for the regional payment disparity issue, and less predictability in the program.

I also want to focus on the additional administrative burden of new regulatory requirements. We've talked about them here today.

Over 830 pages of them, they will affect every aspect of my health plan and my provider's. It will cost my health plan somewhere between $1 million and $2 million additional per year to come into compliance with all of the regulations that are required, and that's for 35,000 enrollees.

It will impact provider contracting, legal and regulatory requirements, grievances and appeals, quality assurance, marketing and sales, member communications. There is no aspect of my health plan that won't be touched by this very important piece of legislation.

It's important to note that over the 14 or 15 years that we have been in the Medicare program, my health plan has lost $35 million. With the current situation, the health plan and its providers saw no light at the end of the tunnel, and had to exit four counties.

To avoid the negative impact of the BBA, certain midterm corrections could mitigate the fallout we might see if current regulations remain as is. First, the national and local blend in payment rates must be achieved immediately to assure viability of a national Medicare risk program and to realize the intent of the law as it was originally passed.

Second, the risk adjusted methodology must be modified so that it is accurately based on all relevant data, ambulatory and inpatient. Third, to provide time to achieve an appropriate methodology, risk adjustment schedules for the year 2000 payments should be delayed. And fourth, administrative aspects of the BBA should be phased in over a longer period, beginning with patient protections, followed by quality improvement programs, disease management, and chronic care efforts.

In closing, I support the BBA and the work this committee did and its recommended changes in many areas. I believe we should move quickly to correct the geographic equity issue and move with more measured steps on requirements that would make the program less flexible for seniors.

Health plans like mine are struggling to implement all of the changes necessary for the BBA. For many of my staff people, it has become their night job. We want to work with HCFA and Congress to find ways to keep the program predictable and affordable.

Thank you, Mr. Chairman.

[The prepared statement of Patricia A. Riley follows:]

PREPARED STATEMENT OF PATRICIA A. RILEY, VICE PRESIDENT OF GOVERNMENT PROGRAMS, ALLINA HEALTH SYSTEM ON BEHALF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS

Mr. Chairman and members of the Committee, my name is Patricia Riley. I am the Vice President of Government Programs at Allina Health System. Allina is an integrated health care system operating in Minnesota and the upper midwest. Allina is a charitable, 501(c)(3) corporation composed of hospitals, nursing homes, clinics, and managed care health plans. Medica is a managed care health plan owned by Allina. It is a non-profit organization that is NCQA accredited and governed by a Board made up of over 50% physicians.

Medica has a long standing commitment to serving seniors and currently serves over 70,000 older Minnesotans. Medica was one of the first Medicare risk demonstration projects in the nation and entered into a risk agreement with HCFA in 1984. Despite below average reimbursement levels in Minnesota, Medica has for over fifteen years continued to support and develop innovative Medicare coverage for seniors. This has entailed going above and beyond regulatory requirements by establishing preventive and supportive services to our members, including informa-

tion and referral, social workers, volunteer matching, health assessments, health education and disease prevention programs. Medica was also the first health plan in the country to design a special care program for low income seniors who are eligible for both Medicare and Medicaid.

Medica's commitment to seniors shows in the loyalty and satisfaction of its membership. Over 95% of our senior members are satisfied and would recommend the plan to others. Our voluntary disenrollment rate is 2%. Medica has lost over $35 million since the inception of its risk program, so I can safely say that you are not hearing today from an organization that is wanting to exit the program because it might not turn a profit. Medica has been effective and innovative despite previous financial hardship, but in the face of additional cumulative costs and administrative burdens established under the Balanced Budget Act of 1997, we must now question the viability of a longstanding commitment to the Medicare Risk product.

I appreciate the opportunity to appear before you today because Allina was active in the development of and supported many of the concepts enacted through the BBA, especially those relating to patient protections. My comments today are threefold. First I will discuss the extreme challenges arising out of the cumulative impact of the BBA regulatory changes, both financially and administratively. Second, I will describe the impact of the difficulties for my organization and how this will impact seniors in my state. Third, I would like to propose some changes that could ease the unintended burden and impact of the BBA, while still attaining its goals.

The cumulative administrative burden of the BBA is staggering. Medica had previously incorporated many concepts within the BBA. Even so, we anticipate the increase in cost to achieve all administrative aspects of the law to be between $1-2 million *annually* for 35,000 risk members. Every aspect of our business will be impacted from how we collect, track and keep records, to contracting with providers, to technological systems to coordinate and monitor care, to maintaining quality assurance. Even in the areas where Medica was already ahead of its time and complying in concept with the BBA, regulatory requirements will force us to significantly modify the way we achieve and report the results sought under the new law. The administrative burden is further increased because the implementation timeline to comply with the new regulations forces increased staffing to levels never before attained. This is especially true in the areas of quality assurance, health assessments and care management. It is very difficult to add so many administrative burdens at a time when federal reimbursement is being reduced. The only option health plans have is to increase member premiums. On average, Medicare risk members in Minnesota already pay $65 in premiums each month for health care coverage that provides less than individuals who pay nothing in many other parts of the country.

The cumulative financial burden of the BBA is also daunting. Minnesota worked for years to attempt to achieve equitable payment rates compared to other regions in the country. The BBAs plan for equity has been delayed by postponing implementation of national/local blended rates. In addition, other financial aspects of the BBA have further ratcheted down already insufficient rates. For at least two years, plans have been limited to two percent payment updates, which were further reduced by user fees and, a carve out of funds for general medical education. Potential future changes due to risk adjustment suggest that Medica could see capitation payments drop as much as 7% or at best possibly rise 2%. Thus, not only is the risk adjustment method itself uncertain as to its effect, but it is flawed in that it is based only on inpatient data and therefore actually penalizes plans which provide effective, appropriate care in lower cost settings. This will be especially harmful in Minnesota where great strides have been made through dual eligible and other innovative programs that assist members in receiving care in the least intrusive, yet appropriate setting.

The impact of the BBA on Medica, on providers, and on Minnesota seniors is already being felt. In the face of the BBA, key Medica contracting providers saw no light at the end of the tunnel and terminated their agreements with Medica as of the end of this year. As a result, Medica is eliminating four counties within its eight county service area, impacting 10,000 Medicare members. At least one of the three other health plans in Minnesota face similar issues. Remaining choices in the state consist of joining one of two small risk plans (each have under 500 members), or returning to Medicare fee-for-service and purchasing supplemental coverage at higher premiums. Thus, as of 1999 when Medicare+Choice will be unveiled, at least 10,000 older Minnesotans will have fewer choices at higher prices than they did a year ago. Many will likely return to Medicare fee-for-service.

We are strong supporters of the BBA and its intent. I believe certain mid-term corrections could help preserve the intent that this committee envisioned. First, the national/local blend in payment rates that Congress passed into law must be

achieved immediately to assure viability of a national Medicare risk program and realize the intent of the law as originally passed. Without the blend, Medicare beneficiaries will continue to be subject to premium and coverage inequities and viability of health plans in lower reimbursement areas will be threatened.

Second, the underlying payment methodology must be modified so that it is accurately based on all relevant data, ambulatory and inpatient, rather than perpetuating the misdirected and wrongly-incented PIP-DCG rate currently proposed. This will ensure that future payments are appropriate and based on health status and need as intended under the law.

Third, to provide time to achieve an appropriate methodology, risk adjustment scheduled for year 2000 payments should be delayed until an appropriate methodology can be implemented. Early implementation of flawed payment rates could create more problems than they solve, especially a system that is based soley on care delivery in inpatient settings.

Fourth, administrative aspects of the BBA should be phased in over a three to four year period, beginning with patient protections, followed by quality improvement components of quality assurance, followed by disease management and chronic care efforts. Each of these should be a focus in separate years. Implementing too much at once will result in poor quality programs with inconsistent implementation and follow up, thereby jeopardizing the likelihood of improved health outcomes.

Without these changes, we will begin to see health plans with long standing commitment and proven track records unable to continue serving seniors. This will leave Medicare beneficiaries facing less choice, higher costs, and less stability after Medicare+Choice than before it. Consequently, beneficiaries could flock back to Medicare fee-for-service in greater numbers than they are today. Each of these results would be in stark contrast to the very goals of the BBA. The BBA has many laudable concepts and goals, but to achieve them we must move in measured steps that will establish a foundation for health plans to survive so they can support the needs and improve the health of older people.

Thank you again for your time and attention. I appreciate the opportunity to share my thoughts and concerns and would be happy to answer any questions.

Mr. BILIRAKIS. Thank you. Ms. Ignagni, would you like to use the balance of her time?

Ms. IGNAGNI. Yes, Mr. Chairman, thank you very much.

Mr. BILIRAKIS. Please do so.

STATEMENT OF KAREN IGNAGNI

Ms. IGNAGNI. As you know, at AAHP, we represent virtually all of the Medicare risk contractors, those that seek to participate in Medicare+Choice, and those that seek to provide new products that are not now currently being provided through risk contracts.

We supported the objectives of the BBA; we still do. But we are coming to you today, and have come to HCFA and the Bipartisan Commission with the same message, that the long-term solutions for this program depend on midcourse corrections.

Our testimony, I hope, Mr. Chairman, will be helpful to the committee in laying out our concerns and issues. We have had a series of correspondence exchanged with the agency. We would be happy to comment on that, happy to comment on the timing question that was raised by a number of members of the committee, and happy to participate in the beginning of an effort to get it right.

Thank you.

[The prepared statement of Karen Ignagni follows:]

PREPARED STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CEO, AMERICAN ASSOCIATION OF HEALTH PLANS

Mr. Chairman and members of the Committee, I am Karen Ignagni, President and Chief Executive Officer of the American Association of Health Plans (AAHP), which is the principal national trade association representing HMOs, PPOs and other network-based health plans throughout the United States. The Association represents approximately 1,000 member plans serving over 140 million Americans.

AAHP's membership includes all but one of the top 25 Medicare risk contractors, whose members represent an overwhelming proportion of Medicare managed care enrollees. I appreciate the opportunity to participate in today's hearing on the implementation of the Medicare+Choice program.

As of September 1998, 6.5 million Medicare beneficiaries—representing 17.2 percent of the Medicare population—were enrolled in health plans. Five years ago, only 7.1 percent of the Medicare beneficiaries were enrolled in health plans According to the Health Care Financing Administration (HCFA), an average of 70,000 Medicare beneficiaries joined health plans each month during the first nine months of 1998. As of September 1998, HCFA had entered into 347 risk contracts with health plans, compared to 303 one year earlier. Many of these health plans have been serving Medicare beneficiaries for almost 20 years.

AAHP and its member plans have long been committed to expanding the health plan choices available to our nation's Medicare beneficiaries. With the passage of the bipartisan Balanced Budget Act (BBA) of 1997, our nation's beneficiaries, health plans, and lawmakers endorsed this principle and pledged to work together to modernize and strengthen the program. Unfortunately, as you are well aware, some health plans have decided to end their participation in the Medicare program. The current situation has serious ramifications for millions of beneficiaries, the Medicare+Choice program and the overall Medicare program. We are here today to offer our suggestions on both short- and long-term corrections to ensure that health plan participation in Medicare remains strong and that the BBA vision of greater choice for beneficiaries becomes reality.

Potential and Challenges of Medicare+Choice Program

In our view, the creation of the Medicare+Choice program has the potential to be one of the most important developments in Medicare since its inception. If structured and implemented properly, this new program holds great promise for improving health care delivery and quality for Medicare beneficiaries and, at the same time, contributing substantially to the program's long-term viability.

Whether this promise is achieved depends largely on the extent to which Congress and HCFA are willing to make mid-course corrections—both legislative and regulatory—as the program evolves over the coming months. As Congress carries out its oversight responsibilities, we urge you to recognize that health plans—many of which have been long-term participants in Medicare—participating in the new Medicare+Choice program are facing a number of unanticipated, unintended problems that are now threatening to undermine choices for Medicare beneficiaries and that a review of all the elements of implementation needs to be undertaken to ensure the success of the Medicare+Choice program.

These problems have resulted from the convergence of several factors, including the fact that the BBA calls for many sweeping changes in an extremely short timeframe and the reality that with its new types of plan options, new requirements, and new payment methodology the Medicare+Choice program is very complicated. HCFA's approach to implementing the BBA reforms has added to these challenges.

The Medicare+Choice program is critical to strengthening and stabilizing Medicare over the long term. No one should be alarmed by the fact that a certain amount of fine-tuning is needed. AAHP and its member plans remain strongly convinced that the BBA moves Medicare in the right direction. The message we bring to you today is that, even though a number of problems threaten to undermine the intent of the BBA, they are not insurmountable and each can be remedied. Congress and HCFA, by making the necessary mid-course corrections, can take action to assure that the Medicare+Choice program provides beneficiaries with access to high quality, cost-effective health plan options. AAHP and its member plans stand ready to provide assistance as policymakers work to understand the combination of factors that threaten the success of the Medicare+Choice program. We emphasize that it is in everyone's interest—including beneficiaries, providers, health plans, HCFA and Congress—for the BBA to achieve its full promise.

Overview of Impediments to Successful Medicare+Choice Program

The many requirements placed on health plans by the BBA, as well as the aggressive timeframe stipulated by the BBA, have challenged both health plans and HCFA. Medicare+Choice plans are currently in a situation in which they face impossible time frames for complying with regulatory requirements for which HCFA has provided insufficient guidance. Many of the new requirements established by the Medicare+Choice regulations will necessitate significant modifications to health plans' operations, information systems, and provider contracts.

AAHP and its member plans have had opportunities to work with the Agency, but often on short notice, limiting our ability to provide meaningful input on critical

issues. Moreover, even when we have been able to provide meaningful input, the Agency has set time schedules that do not allow for full consideration and subsequent action. Today, I want to talk about a number of issues which, if not addressed, will threaten the viability of the Medicare+Choice program. These issues include the need for a transition period for compliance with the Medicare+Choice regulations, concerns relating to adjusted community rate (ACR) submissions, Medicare+Choice payment issues, the Quality Improvement System for Managed Care (QISMC), regulatory burdens on Medicare+Choice plans, and the Medicare beneficiary information program.

Transition Period for Compliance with Medicare+Choice Regulations

AAHP believes HCFA should, at a minimum, treat 1999 as a transition year for current Medicare contractors transitioning to the Medicare+Choice program. We are asking HCFA to issue guidance to current Medicare contractors indicating that: the implementation time frames may extend beyond January 1, 1999, and full compliance should be achieved as quickly as possible with close consultation between Medicare+Choice organizations and HCFA.

We believe certain provisions of the Medicare+Choice regulations cannot reasonably be implemented in 1999. Specifically, we are concerned that a number of other provisions that have no impact on beneficiaries are completely unrealistic. For example, it is impossible for plans to recontract with every health care provider before January 1, 1999, particularly considering that the Agency has not provided guidance on this matter.

Adjusted Community Rate (ACR) Submissions

AAHP has asked HCFA to allow health plans to amend and refile their ACR submissions. The Agency has the administrative authority to act on this matter. At this testimony's submission, we have not received a decision on this request from HCFA. We would like to highlight this issue, as it is a serious concern for Medicare+Choice plans.

Under the new rules for the Medicare+Choice program, health plans were required to submit their ACRs on May 1, as opposed to the previous November 15 submission date. Health plans have found that they need to devote substantial financial resources to comply with Medicare+Choice regulations that were published after the original ACRs were submitted. To compound this situation, since the May 1 filing deadline, health care input prices have risen well beyond the levels that were initially anticipated and these higher prices were not reflected in health plans' ACR submissions.

These factors, along with payments that are lower than had been anticipated upon the BBA's enactment, have resulted in a significant number of health plans announcing their intentions to withdraw from certain Medicare markets and expressing their concern about the long-term viability of the program. These unanticipated factors and events are now threatening to diminish choices and benefits for Medicare beneficiaries and undermine the goals of the BBA. To address these immediate concerns, AAHP has requested that Medicare+Choice plans be allowed an opportunity to amend their ACR proposals. Allowing health plans to restructure their benefit offerings and recalculate copayments and premiums may help restore choices for beneficiaries in many areas where health plans have withdrawn and also help to facilitate new choices for beneficiaries in other areas.

On a related matter, we have concerns pertaining to HCFA's plans for implementing a new approach for filing of ACR proposals. This approach may require extensive systems changes for current contractors transitioning to the Medicare+Choice program. Health plans will need adequate time to make these systems changes. HCFA already has stated that it faces significant impediments to attaining Year 2000 compliance. In addition, to meet the reporting requirements of the new ACR, some health plans would have to retroactively capture data they are not currently capturing—which is nearly impossible. Again, it is also important to note that HCFA has given very little time for comment on the new reporting forms and instructions. Although HCFA published a notice in the Federal Register on September 17 requesting emergency clearance from the Office of Management and Budget (OMB), the underlying forms and instructions were not available until September 21, with comments due October 1.

Proceeding in such a hasty fashion does not allow sufficient time for meaningful input.

Further, the Agency has not yet announced the final version of the filing requirements and contractors are likely to have inadequate time to make systems modifications and prepare to submit ACR proposals under the new rules on May 1, 1999.

This is particularly important in the light of the BBA requirement that HCFA conduct annual audits of the ACRs of one-third of all Medicare+Choice organizations.

AAHP recommends that HCFA defer implementation of the new requirements for ACR proposals and apply them initially to ACR proposals due on May 1, 2000. In the interim, we believe HCFA should pilot test the new reporting documents and address issues identified during the testing. If improvements to the current requirements are needed, we would welcome an opportunity to work with HCFA to identify changes that could be made in the near term. In addition, AAHP urges Congress to reexamine the May 1 filing deadline, which will continue to be problematic for the foreseeable future.

Medicare+Choice Payment

Methodology: With respect to payment for Medicare+Choice plans, AAHP has strong concerns that the payment methodology included in the BBA is resulting in payments that are falling seriously behind the rate of medical care cost inflation and could lead to limiting—rather than expanding—the health plan choices available to Medicare beneficiaries. We urge Congress to conduct a complete and thorough analysis of the Medicare+Choice payment structure. The changes made by the BBA are complex and the impact on plans and on beneficiaries served by our members is significant.

While some have argued for the need to reduce so-called overpayments to health plans, a recent report by Price Waterhouse illustrates that the BBA payment reforms alone dramatically reduce growth in capitation rates to health plans compared to pre-BBA payment levels. The study found that enactment of the BBA reduced average payments relative to the fee-for-service program to 94 percent in 1998 and will drive them down to 89 percent in 2003. Embedded in this average are several counties with large numbers of Medicare enrollees in which government payments on behalf of managed care enrollees relative to fee-for-service payments will fall even further by 2003.

We are beginning to see the cascade of events caused by the disparity in payments to plans relative to fee-for-service. For example, health plans are experiencing difficulties in maintaining adequate Medicare provider networks because providers are unwilling to accept lower payments. Health plans are carefully assessing their ability to offer and sustain over the long-term a high-quality Medicare product. The disparity in payments ultimately affects beneficiaries who will be left with fewer choices, fewer benefits, and higher costs.

Risk Adjustment: Further exacerbating these problems is the risk adjustment methodology that is scheduled under the BBA to be implemented beginning in the year 2000. AAHP has consistently supported the goal of ensuring that Medicare payments to health plans are accurate and that they fairly reflect the health care service needs of the Medicare beneficiaries who enroll. We believe that risk adjusting Medicare+Choice payments should be implemented only in a manner that will improve payment accuracy and result in the least disruption possible to beneficiaries and plans participating in the program.

Our member plans have expressed serious concern that implementation of a risk adjusted payment methodology in 2000 will further reduce capitation payments relative to the fee-for-service program. Payments to Medicare risk and Medicare+Choice contractors already are reduced by a specified percentage to adjust for "perceived" differences in risk between the managed care and fee-for-service programs. The BBA also phases out payments for graduate medical education from health plan payments. The net effect is a growing disparity in payments to health plans payments relative to fee-for-service payments.

HCFA had stated that its proposed risk adjustment method could reduce health plan payments by as much as an additional eight percent, on average. Contrary to ensuring predictability and stability in the new Medicare+Choice program, this type of risk adjustment, applied after the other reductions in payments, will undermine the intent of the BBA by adversely affecting existing markets and by restricting both new market entrants and potential expansions, leaving beneficiaries with fewer options, reduced benefits, and higher out-of-pocket costs.

It is perhaps illustrative to examine HCFA's initial use of a risk adjuster based solely on hospital utilization data. Many of our member plans have expressed concerns about this approach as it creates incentives for increased inpatient utilization, and penalizes health plans that have developed programs to reduce unnecessary hospitalizations for chronically ill members who otherwise would have been treated in inpatient settings. We have urged HCFA to address this important issue prior to implementation of any proposed risk adjustment methodology.

AAHP recommends that implementation of any new risk adjustment mechanism be delayed to allow for a thorough discussion and resolution of important implemen-

tation issues. Delaying implementation will permit the development of a more reliable database, provide the opportunity to review and test the risk adjustment mechanism, and enable an assessment of its potential impact on benefits and health plan participation.

User Fee: AAHP also has significant concerns about the funding of the Medicare beneficiary information campaign. While it is reasonable for health plans and their enrollees to contribute to funding HCFA's enrollment and information dissemination initiatives, their contribution should be in proportion to their participation in the Medicare program. Last year, Medicare risk HMOs and their enrollees represented 14.3 percent of the program, but shouldered 100 percent of the cost of the information campaign. The burden of this fee directly affects the premiums and benefits that health plans can offer to their Medicare members.

While AAHP supports disseminating information to all beneficiaries to enhance informed choice, we believe that an equitable funding mechanism is critical to the success of this effort. The goal of expanded choice is not served if the costs of underwriting the information campaign reduce the level of benefits that Congress sought to make available to more beneficiaries.

Quality Improvement System for Managed Care

Another area of significant concern to our member plans and to many organizations that will be participating in the new Medicare+Choice program is HCFA's proposed Quality Improvement System for Managed Care (QISMC). QISMC is designed to establish a consistent set of quality oversight standards for health plans for use by HCFA and state Medicaid agencies under the Medicare and Medicaid programs, respectively. AAHP has long advocated coordination of quality standards for health plans in order to maximize the value of plan resources dedicated to quality improvement. While we believe that QISMC holds the promise of contributing to this important goal, we have a number of serious concerns regarding its implementation.

At the time of this testimony's submission, the lack of clear coordination with existing public and private sector accreditation and reporting requirements and standards remains a prime concern. Health plans currently meet voluntary private accreditation standards, such as those developed by the National Committee for Quality Assurance, and undertake quality improvement projects in order to satisfy requirements of private sector purchasers and some states.

As numerous studies demonstrate, health plans provide high quality care. AAHP member plans are proud of the care they provide to Medicare beneficiaries, including those with multiple chronic medical conditions. Health plans participating in the Medicare program have made numerous advances in quality measurement and outcomes through private initiatives. We are concerned that government programs do not adequately recognize these initiatives or coordinate more effectively with them. Furthermore, we are also concerned that the Medicare program does not pay equal attention to the overall quality of care furnished under the fee-for-service program. Health plans also participate in numerous HCFA-sponsored quality initiatives.

Every two years, health plans participating in Medicare undergo monitoring reviews that include oversight of quality of care and quality of service. On an annual basis, health plans collect and submit Medicare HEDIS data to assist HCFA in tracking plan performance and they administer the Consumer Assessment of Health Plans Study (CAHPS) to assess beneficiary satisfaction. This fall, through Medicare-participating health plans, HCFA will undertake another quality initiative—the Health of Seniors survey—which the Agency believes will be a tool for assessing outcomes of care. Rather than coordinate with these existing initiatives, QISMC appears to establish an entirely new system of requirements and seemingly undermines its own intent. This results in the use of premium dollars for duplicative/redundant measurement, in effect stealing resources away from patient care.

Of equal importance, QISMC fails to establish realistic goals for health plan activities and performance. For example, QISMC requires that in conducting a quality improvement project, plans show demonstrable improvement defined as a 10 percent reduction in adverse outcomes. Health plans also must sustain this improvement over time. Meeting these requirements may be difficult and in some instances, could be counterproductive. Systematic quality improvement is one of the principal goals of health plans. However, quality improvement projects often require several years before sustained improvement can be achieved, and in the early years a health plan may be out of compliance even though the project's ultimate outcome is highly desirable. Simply stated, these standards may create disincentives to select more difficult, but meaningful projects that a health plan has identified as a high priority for the plan and its Medicare and Medicaid members.

HCFA plans to issue the final draft of QISMC without an opportunity for further comment. Given the initiative's enormous implications, we do not believe this is the

best approach to take. Rather, AAHP recommends that implementation of QISMC be delayed until January 1, 2000 which would allow time for HCFA and health plans to engage in an intensive dialogue to permit full consideration of their serious outstanding concerns about the QISMC standards and guidelines. In addition to the concerns outlined above, we believe that far more consideration should be given to the applicability of QISMC standards to all types of Medicare+Choice plans. We are eager to work collaboratively with HCFA to develop an approach to future health plan quality oversight activities under Medicare and Medicaid that is responsive to the interests of beneficiaries, health plans, and federal and state responsibilities under the Medicare and Medicaid programs.

Administrative Burden on Medicare+Choice Plans

The greatly increased regulatory burden and short implementation schedule are serious impediments to the success of the Medicare+Choice program. In developing the regulations, HCFA has been overly expansive in interpreting the statute. For example, HCFA has promulgated regulations—such as those governing provider-plan relationships—for which there is no statutory basis. This issue, along with others, is addressed in our sixty page comment letter on the Medicare+Choice regulation.

Given what is at stake, HCFA should undertake an immediate analysis to develop a full understanding of the costs associated with the proposed regulation's relationship to the value to beneficiaries and the Medicare program. To the best of our knowledge, no such comprehensive analysis has been undertaken. We believe strongly that a number of these resources could be better directed to the provision of patient care. Indeed, one Midwestern Medicare health plan that provides care for 35,000 Medicare beneficiaries recently estimated that its compliance costs next year alone would be in excess of $1 million and could reach $2 million.

Further complicating implementation of the regulation is HCFA's unreasonable expectations regarding compliance. Let me assure you that health plans are working diligently to ensure that they will come into compliance with Medicare+Choice requirements. Nor do I want to suggest that health plans are shirking their responsibility to be held accountable for their performance. However, in some instances, the regulation is structured in a way that sets plans up to fail.

For example, the regulation requires that Medicare+Choice plans conduct a baseline assessment of all new beneficiaries—something which is virtually impossible to accomplish given beneficiaries' right to refuse to participate in the assessment. In addition, the regulation requires certification by an organization's CEO of the absolute accuracy and completeness of all information related to payment, notwithstanding the fact that this information frequently is drawn from contracting providers.

The current situation supports the call for more time: more time for HCFA to understand fully the costs associated of implementing the regulation compared to the value it brings beneficiaries and more time for health plans to come into compliance with the regulation. As currently drafted, the Medicare+Choice regulation will require extensive new compliance activities that must be initiated even before, in some cases, the Agency has issued detailed guidance to supplement the regulations. Health plans will need sufficient time to carry out necessary modifications to policies, procedures and systems. For this reason, and as mentioned previously, AAHP believes HCFA should, at a minimum, treat 1999 as a transition year for current Medicare contractors transitioning to the Medicare+Choice program.

Medicare Beneficiary Information Campaign

Finally, I would like to discuss the Medicare beneficiary information campaign, which is financed with the user fee discussed earlier in our statement. AAHP is concerned about the cost of this campaign. Congress appropriated $95 million for these activities in 1998 and suggested that HCFA focus first on developing and publishing the comparative information booklet; this year, the Agency is seeking $150 million for FY99. However, in June 1998, HCFA announced that it would scale back plans to distribute Medicare handbooks to 38 million beneficiaries and instead pilot test the handbook in five states, reaching only 5.5 million beneficiaries. In addition, HCFA is phasing in over 12 months implementation of the toll-free call center. Yet HCFA has collected close to its full 1998 assessment of $95 million from health plans.

The 1998 assessment of $95 million was intended to inform all beneficiaries about their options under the Medicare+Choice program, not just a subset of these beneficiaries. While we support a scaled-back, more thoughtful process for the campaign, a significantly scaled-back program raises questions about HCFA's use of the full 1998 assessment. HCFA should be held accountable for the FY98 assessment collected from health plans, especially since the reduced activities should be reflected

in reduced FY98 expenditures. To the best of our knowledge, HCFA has not yet provided detailed information on the budget, resource allocation, or expenditures for the beneficiary information campaign for FY98. Furthermore, the very limited budget information that the Agency has made available indicates that costs for the beneficiary education campaign are significantly higher than those borne by other federal agencies or the private sector for similar activities.

AAHP supports efforts to enhance informed beneficiary choice. However, we are concerned about the general design of HCFA's program and whether the information provided will be meaningful to beneficiaries. For example, it is unclear whether the information to be contained in the national bulletin will provide needed information or simply raise more questions among beneficiaries. For most beneficiaries, the transition to the Medicare+Choice program will have little impact until and unless new health plan options begin to be available in their market areas. Given this, sending materials discussing new programs that remain unavailable to beneficiaries may be more confusing than informative.

AAHP and its member plans will continue to work with HCFA, beneficiary groups and others to develop a campaign that provides beneficiaries accurate, timely and meaningful information to beneficiaries. The central goal of this initiative, to provide more and better information to beneficiaries about all of the options available to them, is critical to permitting beneficiaries to take advantage of the expanded range of choices envisioned under the new Medicare+Choice program. Achieving this goal, in part, depends on a directed effort to collect data on quality of care under the traditional Medicare program comparable to the data collected and reported by HCFA on Medicare managed care plans. Ensuring that there will be choices to describe in the information in large measure depends on the mid-course corrections for which we are calling.

Conclusion

AAHP and its member plans are firmly committed to the successful implementation of the Medicare+Choice program. While we recognize that there are many significant challenges in this implementation effort, we believe the solid track record of the Medicare risk contracting program demonstrates the potential of the Medicare+Choice program to offer valuable options to Medicare beneficiaries. Our specific and immediate recommendations with respect to implementation of this program follow:

1) HCFA should permit health plans transitioning to the Medicare+Choice program to amend their ACRs proposals within parameters that will allow the Agency to expedite review.
2) HCFA should clarify the compliance standard by notifying current contractors transitioning to the Medicare+Choice program that 1999 will be treated as a transition year.
3) Implementation of any new risk adjustment mechanism should be delayed until at least January 1, 2001.
4) HCFA should delay implementation of QISMC until January 1, 2000 at the earliest.

Although these recommendations will help provide mid-course corrections, a review of all of the elements of implementation needs to be conducted to ensure the success of the Medicare+Choice program and to lay the foundation for the long-term viability of Medicare. We look forward to continuing to work with Congress to assure that the full potential of the Medicare+Choice program is achieved.

Mr. BILIRAKIS. Thank you very much. Our former colleague who we are very happy to see often. Although, apparently we won't be seeing too much of you in a short while from now, Bill Gradison, President of the Health Insurance Association of America. Bill.

STATEMENT OF BILL GRADISON

Mr. GRADISON. Thank you, Mr. Chairman. I am Bill Gradison, President of the Health Insurance Association of America. We very much appreciate this opportunity to share with you a few of our concerns about the implementation of Medicare+Choice, a program which we wholeheartedly support.

We believe that the central purpose of Medicare+Choice is to restructure the Medicare program in order to deliver high quality, cost-effective health services to Medicare beneficiaries through a

broad array of private health plans, and we strongly support this goal.

As a matter of fact, we believe that Medicare+Choice reforms are critical to sustaining the Medicare program for the next generation of Americans. I applaud Chairman Bliley and Bilirakis and all the other members of this committee who played such key roles in crafting the Medicare+Choice reforms.

We and our members companies are committed to working with Congress and HCFA to fully and successfully implement the Medicare+Choice program. Implementing the reforms enacted in BBA 97 presents challenges, some of which result from the ambitious implementations schedule.

We recognize that Congress was eager to expand beneficiaries' choice of private health plans as quickly as possible. However, we are concerned that the extremely tight timelines may deter plans, both current Medicare risk contractors and new organizations, from participating in Medicare+Choice.

We also have encouraged HCFA to allow a longer transition period to fully implement the program and to seek authority from the Congress, where necessary, to accomplish this. The ambitious implementation schedule, in our view, is a real problem, but it is a short run problem.

In my remaining moments, I would like to focus on several fundamental concerns: the adequacy of payments to plans and flexibility for plans to operate without excessive regulatory burden, which we believe could jeopardize the long run success of the Medicare+Choice program.

On an ongoing basis, payments to plans must be sufficient to cover the costs of efficiently delivering high quality medical benefits to beneficiaries. The reality is that under the new formula, payment increases to the plan serving the preponderance of Medicare+Choice beneficiaries will be well below projected medical inflation.

Compounding this problem, both HCFA and the Medicare Payment Advisory Commission project that payments to Medicare+Choice plans in the aggregate are likely to be significantly reduced with the January 2000 implementation of the new risk adjustment mechanism.

Mr. Chairman, our understanding was that savings from the percentage reduction in payment updates were agreed to lieu of net program savings from risk adjustment, and we would hope that the intent of the Congress on that point might be clarified.

Under these circumstances, either beneficiaries will experience significant premium increases and cutbacks in benefits or many plans, plans that want to stay, may decide they are not able to continue in the program.

We strongly urge the Congress to allow a slower phase-in of changes in the Medicare+Choice payment methodology, and we will be working with HCFA and other industry groups on specific recommendations. We believe that in enacting Medicare+Choice, Congress intended to provide Medicare beneficiaries with a range of plan choices similar to the options available to most working Americans and to harness the creativity of the private sector to realize

market-driven increases in efficiency, quality, and beneficiary satisfaction.

Without future changes in HCFA's regulatory approach and certain adjustments in the law, we are concerned that neither of these goals will be realized. That is, the range of private plan options may expand very little beyond HMO's and HMO-like plans, and the significant costs of striving to meet such extensive and detailed regulatory requirements, dollar costs, personnel costs, the energy that goes into it, will divert plan resources from providing the types of products and the level of service that beneficiaries demonstrate they want and that you have demonstrated by your action last year that you want as well.

I don't have time here to fill this picture in for you. My detailed statement, which I hope you will include in the record, goes into further examples, detailed examples as to why we believe many organizations will choose not to offer PPO, MSA, or private fee-for-service plans.

I just want to point out that we see a basic incompatibility between administering a government program through extensive and prescriptive regulations—which really is Medicare of the past—and relying on private market forces and an environment where government defines basic consumer protection safeguards, and plans are driven by and have the flexibility to meet the preferences of informed consumers.

In conclusion, let me stress again, we believe that Congress, the administration, and our member companies share a common goal: successful implementation of Medicare+Choice. Based on the record of the first year, we feel that following the current path may lead to disappointment for us all and most especially for Medicare beneficiaries.

We look forward to working with you, Mr. Chairman, in the future to address these problems so that they can be resolved in the interest of the program, and especially in the interest of the beneficiaries. Thank you.

[The prepared statement of Bill Gradison follows:]

PREPARED STATEMENT OF BILL GRADISON, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. Chairman and Members of the Committee, I am Bill Gradison, President of the Health Insurance Association of America. As the nation's preeminent health insurance trade association, the Health Insurance Association of America (HIAA), based in Washington, D.C., is the industry's most influential advocate for the private, market-based health care system. HIAA's more than 250 member companies provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection, to more than 65 million Americans. HIAA develops and advocates federal and state policies which would build upon our health care system's quality, affordability, accessibility and responsiveness.

I am pleased to have this opportunity to discuss the implementation of the Medicare+Choice program with you, and to share with you a few of our concerns. Many of the structural reforms called for in an earlier HIAA proposal [1] were enacted last year as part of the Balanced Budget Act of 1997 (BBA 97). HIAA congratulates the Commerce Committee for enacting these bold Medicare reforms which, indeed, represent the dawning of a new era.

BBA 97 helped put in place the basic building blocks necessary to transform the program—and the agency that administers it—from a passive payer and regulatory

[1] Health Insurance Association of America, Bringing Medicare into the Twenty-first Century, 1996.

behemoth to a dynamic benefits manager. The program, still dominated by a centralized, price-controlled, 1960's fee-for-service delivery system model, must now dedicate its resources and energy to nurturing the growth of new private health plan options and educating beneficiaries about these options.

HIAA members include companies currently serving as Medicare managed care contractors who will be shifting to Medicare+Choice organizations, as well as other companies who are considering becoming Medicare+Choice contractors. While HIAA members are interested primarily in the possibility of offering coordinated care plans under the Medicare+Choice program, some have expressed an interest in offering private fee-for-service and medical savings account plans as well. HIAA members offering Medigap and Medicare Select products also have an interest in the Medicare+Choice program, to anticipate the program's impact on their current products and potentially to contract with HCFA to offer Medicare+Choice products.

HIAA SUPPORTS THE CENTRAL PURPOSE OF THE MEDICARE+CHOICE PROGRAM

HIAA believes that the central purpose of Medicare+Choice is to restructure the Medicare program in order to deliver high-quality, cost-effective health services to Medicare beneficiaries through a broad array of private health plans. We strongly support this goal. As a matter of fact, HIAA believes that the Medicare+Choice program, and its inevitable influence on the broader Medicare program, will be extremely important in moving Medicare into the twenty-first century and that its reforms are critical to sustaining the Medicare program for the next generation of Americans.

Accordingly, HIAA and its member companies are committed to working with Congress and the Health Care Financing Administration (HCFA) to fully and successfully implement the Medicare+Choice program. Clearly, the reforms enacted by BBA 97 will require significant structural changes to what is already an extraordinarily complex program. Implementing the Medicare+Choice program will be difficult in light of the breadth and complexity of the policies in the proposed rule, the far-reaching and complicated nature of the Medicare program, and the economic, cultural, and medical diversity of Medicare beneficiaries. Setbacks are inevitable as the program undergoes significant transition. We hope that HIAA and its members, working together with Congress and the Administration, can identify and avoid as many of the potential pitfalls as possible. We look forward to building a long-term partnership between our member companies, Congress, and the Administration to make Medicare+Choice an attractive option for the nation's seniors and people with disabilities.

CONCERNS ABOUT ANTICIPATED MEDICARE+CHOICE ORGANIZATION PAYMENTS

Perhaps the greatest threat to the success of the Medicare+Choice program is the collective impact of changes in Medicare's capitation payment methodology. In order to achieve a successful partnership between the federal government and Medicare+Choice organizations, program rules must: (1) allow payment rates that recognize and adjust for the actual costs of providing health care and permit necessary investment for clinical and operational improvements, and (2) incorporate financial incentives to reward those Medicare+Choice organizations that achieve the government's economic, clinical and operational performance objectives.

1. Limits on Annual Increases in Capitation Rates Render the Medicare+Choice Program Unsustainable Over Time.

The BBA 97 and Sections 422.252 and 422.254 of the proposed rules will limit capitation rate increases for Medicare+Choice organizations serving the largest proportion of Medicare beneficiaries in a fashion that will not keep pace with the growth in health care costs. This will mean reduced access and choice for Medicare beneficiaries, and/or reduced economic value of the benefit packages offered by Medicare+Choice organizations.

As set forth in Section 1853(c) of BBA 97, Medicare+Choice organizations will be paid the greater of: (a) a blended capitation rate, which is the sum of a percentage of the area-specific capitation rate and a percentage of the national Medicare+Choice capitation rate (the percentage balance will change over time until the percentage is 50/50 in 2002); or (b) a minimum amount, which is, in most instances, $367 for 1998; or (c) a minimum percentage increase for 1998 equal to an increase of 102 percent of the 1997 Adjusted Average Per Capita Cost (AAPCC) rate for the particular county with increases of 102 percent in each subsequent year.

For 1998, not one county was paid on the basis of the blended rate. This is likely to remain true for at least the next couple of years. It is HIAA's understanding that in 1998, 60 percent of counties received the minimum percentage increase while 40

percent received the minimum payment amount. Importantly, the vast majority of beneficiaries reside in areas that received only the minimum percentage increase.

For both the blended rate and the minimum amount payments, rate increases for years 1999 through 2002 equal a percentage increase equivalent to the average increase of Medicare Part A and Part B costs, less a percentage reduction specified by Congress. Only in 2003 (and thereafter) will the increase for the blended capitation rate and the minimum amount rate not be reduced.

For Medicare+Choice organizations serving beneficiaries in counties receiving the minimum percentage increase payment, there is an ongoing limit of 2 percent growth per year in payment rates. Thus, regardless of how significant the increase in underlying health care costs, Medicare+Choice organizations serving beneficiaries in some 60 percent of counties will only see their capitation rates increase by 2 percent.

Simply stated, organizations cannot sustain such arbitrary limitations on capitation rate increases. CBO has projected Medicare Parts A and B outlay increases 1997 to 1998 of 5.8 percent, and 1998 to 1999 of 5.3 percent. While a complete picture is as yet unclear, it has been widely reported that some of the most respected Medicare+Choice organizations in the country are finding it necessary to either withdraw from states and counties with low capitation rates or to increase premiums and reduce benefits.

HIAA urges the Congress to reconsider these artificial and arbitrary limits on capitation rate increases. If these rates are not reconsidered, yet more Medicare+Choice organizations may withdraw from areas served, and beneficiaries can expect additional premium increases or reduced benefits. In this case, the Medicare+Choice program will become only a shadow of what it has the potential to become.

2. The Current Risk Adjustment Policy is Ill-Conceived.

While HIAA believes that improved risk adjustment is an essential long-term goal for the program, the current proposal is problematic in several respects. First, the collection, verification, transmission, and submission of "representative" encounter data is very costly. Thus, basing risk adjustment on the claims and encounter data places significant—and expensive—administrative and technological burdens on Medicare+Choice organizations and all associated medical services providers. Such requirements would create a significant hurdle for new entrants wishing to serve as Medicare contractors and might well deter participation. HIAA believes that all parties would be better served by a less burdensome basis for risk adjustment. To this end, we encourage HCFA to continue exploring alternative methodologies for risk adjustment, including survey-based approaches, and will gladly work with the agency toward this goal.

First, the Medicare Payment Advisory Commission (MedPac) has noted that payments to Medicare+Choice plans in the aggregate are likely to decline significantly with the implementation of HCFA's current risk adjustment methodology. This runs counter to HIAA's understanding of Congressional intent—which is that the savings resulting from the percentage reduction in plan payments for years 1998 through 2002 was intended to be *in lieu* of any net program savings from risk adjustment. This accentuates FHAA's concerns regarding the adequacy of plan payments under Medicare+Choice.

As a practical matter, the time frame is too short for implementation of this risk adjustment policy. Given the technological considerations involved, it is unreasonable for HCFA to require (as it does in Section 422.257) that all Medicare+Choice organizations be able to provide physician, outpatient hospital, skilled nursing facility, and home health data beginning as early as October 1, 1999. Some HIAA member companies that currently contract with HCFA and are beginning the transition to Medicare+Choice do not have the technical capability to capture and transmit encounter data other than impatient encounters. Nor do our members with PPO and similar network-style delivery systems have the capability to capture such data. HCFA's proposed time frame is insufficient to allow Medicare+Choice organizations to procure and install the required systems, even if the capital for such purchases can be arranged. The information technologies required to capture encounter data also should support an organization's efforts to meet the quality standards being proposed. Procuring systems that can accomplish these tasks requires very careful planning and assessment, review of the capabilities of competing technologies and vendors, and time to install the systems, train staff, and verify and validate the data. HCFA should know from its own information technology experiences in recent years that each of these steps must be carefully executed or the system will fail.

Further, the time frame proposed is insufficient, particularly because the model HCFA proposes to employ for making risk adjustments based on encounter data has

yet to be tested. Also, HCFA intermediaries already are reporting problems receiving impatient hospital data. A more realistic approach would be to allow contractors to come on-line as they are ready, when HCFA's intermediaries are prepared to receive the data, and when HCFA is able to use the data in a manner that would assure complete and accurate risk adjustment.

HIAA strongly believes that it is poor public policy to base the initial risk adjustments on impatient hospital data only. This approach will reward Medicare+Choice plans with excessive hospital use, and penalize plans that have effectively reduced impatient hospital use and focused on providing more care on an outpatient basis. The incentives created by a risk adjustment methodology based exclusively on inpatient hospital data, even if applied only for a few years, would result in increased hospital use, increased avoidable costs, and a set back in the effort to realize greater efficiency in the health care system.

Plans with a relatively high proportion of members who receive care for expensive chronic illnesses outside the hospital setting would be particularly harmed. Medicare+Choice must not undermine the valuable incentives inherent in managed care arrangements to provide high quality care in the most cost-effective manner. At the very least, the implementation of the risk adjustment methodology should be delayed until information from a much broader range of health care settings can be gathered and used.

Finally, HIAA believes that it would be a mistake for the program to require (as it apparently does in Section 422.502(l) of the interim regulation) 100 percent "accuracy, completeness and truthfulness" of certain data, including specified enrollment information and encounter data. While it is appropriate to use certification to encourage organizations to use their best efforts to ensure the accuracy of the data that they submit to the government, it is inappropriate for the agency to require anything more than a demonstrated good faith effort. While a goal of 100-percent accuracy for submitted data should be established and Medicare+Choice organizations should be required to work toward that mark, they should not be penalized for inaccuracies despite good faith efforts, especially given the systems problems referenced earlier. Requiring executive officers to certify the accuracy of encounter data from downstream providers and to subject themselves to penalties for inaccurate information is unreasonable, particularly for Medicare+Choice organizations with contracted network delivery systems. This is especially true where, as here, an incorrect certification could in HCFA's view potentially lead to application of the criminal and/or civil false claims acts and the imposition of significant sanctions, including triple monetary damages.

In truth, the rule appears to be designed, not as good public policy, but as a legal trap for those individuals or entities that might submit incorrect data, no matter how innocent the error or how reasonably they may have acted in their collection efforts. This punitive approach will deter participation in the program and create a schism between the agency and its contractors. The regulation should be amended to protect those who provide information that they reasonably believe to be true based on good faith efforts.

3. The User-Fee "Tax" on Medicare+Choice Organizations for Beneficiary Education Is Inequitable and Likely to Undermine Participation.

HIAA strongly supports educating and informing beneficiaries about all coverage options including the Medicare+Choice program and supplying them with straightforward, unbiased information to help them choose appropriate coverage. Without reliable information on which consumers can act, no market can work effectively. We are committed to working with HCFA to ensure that appropriate and useful information is provided in a timely manner to beneficiaries. Our members offering Medicare+Choice plans are also willing to bear their fair share of the costs of assembling and disseminating information that will be helpful to beneficiary decisionmaking.

Our concern is that under that statute, the user fee tax on Medicare+Choice organizations requires that beneficiaries who elect Medicare+Choice plan options (currently about 17 percent) must bear the entire financing burden for education and counseling services provided to all 37 million beneficiaries, including the 83 percent electing to remain in the original Medicare Parts A and B. Considerations of equity dictate that the funding for this essential program activity be derived from the same or similar broad-based mechanisms that support Medicare expenditures in general.

The tax adds insult to injury by further reducing payments to Medicare+Choice organizations that, even without the tax, will not keep up with the increased underlying cost of health care. It claims a portion of the capitation payment that should be both available and needed for patient care. Because of the user fee tax, a good number of existing Medicare risk contractors will see *no increase* in their payment

rates in 1998. As stated earlier, the cumulative effect of the Medicare+Choice organization payment provisions in the interim rule, at a minimum, is likely to deter new health plan organizations from entering the program. We urge the Congress to fund this function from the Medicare trust funds, or another broad based revenue source.

THE REGULATIONS GOVERNING QUALITY ASSURANCE ARE OVERLY RIGID AND DEMANDING

Deliberate and careful attention to quality standards is key to the Medicare+Choice program and to a market-based approach to Medicare. Such standards should serve both to protect Medicare beneficiaries from potential harm and to stimulate Medicare+Choice organizations to improve their services. Indeed, the quality assurance aspect of the program is just as important as economic considerations. Without quality standards, a capitation-based payment approach could quickly devolve into a race to the bottom.

In recent years, some commercial purchasers have turned to standardized performance measurements to assess and compare competing managed care organizations. HIAA members have competed in the private market on the basis of clinical and service performance as well as economic performance. They are willing to do the same in the Medicare+Choice market.

That said, HIAA has serious concerns about the quality standards set forth in the interim rule. We believe that, in the Medicare context as with the commercial market, it is legitimate and necessary to hold different plans to *different* tppes of standards. Performance measures should be designed to fit the services offered by the various plan types. In this regard, HIAA concurs with the concerns expressed recently by the Blue Cross and Blue Shield Association (BCBSA) regarding the Medicare+Choice quality regulations.[2] Under the quality requirements set forth for Medicare+Choice coordinated care plans, we believe it is unlikely that Medicare+Choice PPO plans that offer broad choice of providers to beneficiaries will be available to Medicare participants. Similarly, the extensive government-imposed quality-related requirements applied to MSA plans and private fee-for-service plans are likely to deter the offering of these types of plans. Different plans must be measured against different types of standards, as we note below in the discussion of Medicare+Choice MSA plans.

As also stressed by BCBSA, the extensive data required (or to be required) even from HMOs under the current framework will add significant administrative costs to Medicare+Choice organization operations. We question whether the additional costs entailed by these regulatory requirements are justified or desirable.

HCFA's approach to quality, as reflected in the regulation, imposes a very ambitious quality assurance and performance improvement model on all Medicare+Choice plans. FHAA strongly believes that consumers, not government officials, should dictate through their plan choices the extent and nature of quality improvement, balanced against costs. Within a reasonable mandated quality assurance framework, organizations must be allowed the flexibility and freedom to respond to market incentives for performance. A market-based approach better serves all stakeholders than an elaborate regulatory structure. Beneficiaries can have a wider variety of products from which to choose. Organizations that are responsive to consumer preferences will be rewarded with greater market share. And fewer government resources will be required for oversight.

Thus, HCFA's quality initiatives should focus more on flexible incentive-based standards established through contracts and not on overly prescriptive dictates that would impose penalties on Medicare+Choice organizations for failing to meet regulatory standards rather than provide meaningful positive rewards for good performance. If HCFA's quality efforts result in agency policies that micromanage Medicare+Choice organizations then what has the potential for an effective market strategy to reward high performance could become little more than bureaucratic meddling in organizational decision making.

Even when the required performance data is appropriate to the product, the timelines for implementation should be realistic. Many health care organizations, particularly those with loosely managed network-style delivery systems, including PPOs, do not have the capability to capture or report performance data. The capitation rates offered are insufficient to fund system upgrades. Even if fiscally possible, the procurement, installation, training, and validation time requirements would

[2] Testimony of the Blue Cross and Blue Shield Association on Medicare+Choice Quality Regulations presented to the Committee on Finance of the U.S. Senate, July 30, 1998 by Daniel Lestage, M.D., Vice President, Blue Cross and Blue Shield of Florida.

take years to fully implement. HIAA believes that organizations making a good faith effort to meet the regulatory requirements should be provided a transition period where penalties would not be imposed. This is particularly important given efforts by all health plans to address year-2000 computer issues.

REGULATORY CONFUSION

Consistent with Section 1856 (b)(3) of the Social Security Act, the Medicare+Choice regulations set forth "general" and "specific" preemption of state laws, regulations, and standards. Where state provisions affecting any Medicare+Choice standard are inconsistent with the federal standards, the general preemption recognizes federal law. By contrast, the specific preemption recognizes federal standards in three areas, regardless of whether state provisions are inconsistent with federal standards. These three areas are benefit requirements, requirements relating to inclusion or treatment of providers, and coverage determinations (including related appeals and grievance processes).

1. Specific Preemption.

While HCFA has attempted to develop an appropriate and workable scope of the specific preemption, HIAA strongly believes that the agency's narrow interpretation departs from Congressional intent, and that it will cause significant problems. For instance, it is clear from the regulations that the cost-sharing features of a Medicare+Choice plan are an integral part of the benefit package. Yet, based on the HCFA regulations, in many instances state laws regarding cost sharing would not be preempted. (See 63 Fed. Reg. 35013 [June 26, 1998]).

This is illogical and unworkable. It would result in two potentially different standards concerning Medicare+Choice plan cost sharing. While ultimately any conflict between the two sets of standards would be resolved by the general preemption, a specific preemption with a broader scope would allow plans to operate under one consistent standard.

2. General Preemption.

More generally, there clearly are instances where federal policy should override state concerns. The Medicare program generally, and Medicare+Choice in particular, is one such instance. Medicare is a wholly federal program with policies set by Congress, funding from federal taxes, and universal eligibility for all who are entitled. Rights, costs, and other responsibilities for beneficiaries and for those health care organizations that serve them should, except in compelling circumstances, be set federally for the entire nation, not by the states. To do otherwise would create an unnecessarily complex, confusing, and expensive program to administer.

The experience of Medicare risk contractors under pre-BBA 97 dual regulatory mandates illustrates the untenable situations that can result when both state and federal regulators have authority, but disagree on matters of, for example, rate approvals or policy form approvals. In many such cases, the general preemption rule does not provide clear guidance, resulting in regulatory confusion. The regulatory framework is even more untenable when an organization is subject to laws from more than one state, as would be the case if a plan's service area covered an entire Metropolitan Statistical Area which overlapped state boundaries.

Given the already extensive scope of the proposed federal Medicare+Choice regulations and the anticipated significant number of contractual requirements, state law in this context largely represents a redundant layer of regulation, adding unnecessary costs and confusion, and significantly restricting a plan's flexibility to respond to the market and beneficiary needs. Accordingly, HIAA urges the Congress to broaden the scope of the "general" preemption to ensure that federal law governs and preempts all state laws other than those pertaining to financial solvency.

TIME FRAME FOR MAKING NONEMERGENCY COVERAGE DETERMINATIONS IS INSUFFICIENT

Section 422.568 reduces the time frame for deciding an enrollee's standard request for services from sixty days to "as expeditiously as the enrollee's health condition requires, but not later than 14 [calendar] days." While the Medicare+Choice organization can extend the time frame for deciding by up to fourteen days, an extension is contingent upon (a) an enrollee request or (b) a demonstration by the organization that an extension is necessary and consistent with the beneficiary's interest. For various reasons, HIAA believes that this provision is flawed.

First, the phrase "as expeditiously as the enrollee's health condition requires" is too vague and open to interpretation to prove useful. Moreover, in some cases, the fourteen-day time frame proposed will be too short, as a practical matter, to allow

proper deliberation by the Medicare+Choice organization. To coordinate and manage care, an organization must have adequate time to evaluate individual requests. This often entails obtaining a beneficiary's medical record or other relevant documentation, and obtaining input from one or more physicians regarding the necessity of the medical treatment. This takes time and is all the more difficult for broader network plans, such as PPOs, to accomplish in a short time frame. While HIAA members are committed to providing decisions as expeditiously as possible, the current time frame will be impossible to meet as a general rule.

Finally, it should be noted that, where a beneficiary's health requires a prompt decision, the rules mandate a seventy-two-hour response time. And yet a separate process governs emergency situations. For all other organization decisions, which by definition are those *that do not require* an immediate response, there is not an obvious need for the severe reduction in time allowed for processing requests that is set forth in the Medicare+Choice rules. Accordingly, HIAA recommends that the timeline for responding be extended to at least twenty-eight calendar days, with the possibility of a fourteen-day extension if the additional criteria set forth in Section 422.568 (as detailed above) are met.

THE MEDICARE+CHOICE MSA PRODUCT DESIGN MAKES IT UNATTRACTIVE AS A NEW MEDICARE COVERAGE OPTION

A number of HIAA member companies are interested in serving Medicare beneficiaries by offering MSA plans under the Medicare+Choice program. Most companies have been deterred from developing a Medicare+Choice MSA product, however, by several aspects of BBA 97 and the interim rule. One disincentive is that a maximum of 390,000 beneficiaries are allowed to enroll in MSA plans—too few, given the substantial commitment of time and other resources required to develop and market new products. Beyond this, however, other requirements may make the Medicare+Choice MSA product inherently unattractive to sponsoring organizations and/or to beneficiaries.

The quality framework imposed on all Medicare+Choice plans poses significant problems, as discussed above. In the commercial market, MSA products are attractive to many health plan organizations and consumers as an *altenative* to managed care. The enrollee, rather than a health plan, manages his own (and his family's) routine needs for medical care. Much of the Medicare+Choice quality framework does not fit this approach to health benefits. For example, all Medicare+Choice plans, including MSA plans, are expected to: (1) stress health outcomes and provide for collection and analysis of data to measure outcomes; (2) monitor and evaluate high-volume and high-risk services and the care of acute and chronic conditions; and (3) evaluate the continuity and coordination of care that enrollees receive. Most organizations offering MSA products are not, and do not want to be, in the business of managing health outcomes.

The requirements for reporting encounter data, upon which risk adjusted payment depends, are not feasible for most organizations offering MSA plans, because they do not capture detailed claim data on services received which do not qualify for coverage under the high deductible plan.

In addition, some HIAA members have questioned HCFA's interpretation of BBA 97, in that the agency requires "*community rated*" medical savings account contributions for all beneficiaries enrolled in a given plan. The effect of this determination, together with the fact that the MSA product offers beneficiaries no protection from unlimited balance billing, is expected to significantly diminish demand.

CONCLUSION

If the Medicare program is to be sustained for the next generation of beneficiaries and beyond, it is crucial that the federal government employ every strategy appropriate to provide the highest quality of health care at the lowest justifiable price. In the past, the federal government has relied almost exclusively on regulatory approaches to pursue this objective. HIAA and its members believe it would be wiser to employ market-oriented strategies to both attract Medicare beneficiaries and to create incentives for private health insurers and providers to deliver value in the context of the Medicare program. Because it is a critical building block in this market-based strategy, Medicare+Choice must be successful. We believe that if the comments we offer here are incorporated in the Medicare+Choice regulatory framework, the prospects for success will be greatly improved.

Mr. BILIRAKIS. Thank you, Mr. Gradison. Mr. Sacco, please proceed.

STATEMENT OF DONALD P. SACCO

Mr. SACCO Mr. Chairman and members of the committee, I am Donald P. Sacco, President and CEO of Regence Blue Cross Blue Shield of Oregon. Representative Furse, thank you very much for your kind introduction.

I am testifying today on behalf of 54 independent Blue Cross and Blue Shield plans, and I appreciate the opportunity to share our views about the implementation of Medicare+Choice. Simply put, we are very concerned that the congressional objective of expanding the number and types of health plan options through the Medicare+Choice program will not be met. In fact, we fear that Medicare beneficiaries are likely to have fewer choices next year than they had in 1998.

This is, in my opinion, because the interim final regulations present HMO's with significant new expansive and complex regulations and requirements which carry both civil and criminal penalties for failure to comply. This level of risk does not currently exist in the program. This risk, combined with inadequate payment rates, is forcing health plans to reassess their commitment to staying in the program.

My testimony today is intended to highlight the new and unprecedented business risks and to recommend a rewrite of the regulations to encourage, rather than discourage, participation in the program.

Regence Blue Cross Blue Shield of Oregon is qualified to testify on this issue. As the largest insurer in Oregon, we provide health coverage to over 1 million Oregonians, 81,000 of whom we serve through our Medicare risk cost and supplemental products.

Additionally, as Representative Furse knows, nearly 50 percent of Oregonians are enrolled in HMO's. In fact, in Portland, over 60 percent of Medicare beneficiaries are enrolled in HMO's. Indeed, the Regence HMO experience indicates that our Medicare HMO enrollees are sicker than those who purchase our supplemental program.

My plan, like others, has longstanding ties to our community and our senior citizens. We want to continue offering Medicare beneficiaries an HMO option. The last thing we want to do is tell our beneficiaries that we will no longer be offering them coverage in a program they clearly support.

This would be extremely disruptive for our older enrollees. Additionally, it could place them in a difficult situation where they may be forced to change doctors or face higher costs for their care. I must stress, however, that the business risk of participating in the new program is unprecedented.

As we in Oregon know, inadequate payment rates are difficult enough to manage. The retreat of some health plans from the entire Medicare risk market and the retreat of others from low-cost rural areas is evidence of this fact. Excessive regulation and unachievable timelines for implementation are causing plans to seriously reevaluate their participation.

Let me give you two brief examples. The first is related to quality standards. Though the Health Care Financing Administration has issued another draft of the quality improvement requirements,

it doesn't change the fact that it still goes beyond the statutory authority.

While Congress intended the agency to develop quality requirements, the rule standards go beyond the statute and leading private sector standards in two key ways. First, health plans must meet minimum performance levels on standardized reporting measures. Second, plans must conduct performance improvement projects that consistently achieve 10 percent reductions in adverse outcomes.

The interim final regulations state that failure to meet these requirements may lead to contract nonrenewal or termination. Just 2 days ago, the Health Care Financing Administration released a major revision to the quality standards and we applaud the efforts to respond to our previously expressed concerns.

In particular, we appreciate the reductions in the number and the phase-in of quality improvement projects and the administration's willingness to work with plans through technical assistance or other corrective action plans before moving to contract termination or nonrenewal.

Nonetheless, we remain concerned about the basic reliance on rigid and arbitrary numerical standards. This reliance is simply incompatible with current trends in quality improvement and with the current evolving state of performance measurement.

In response to Mr. Hash's belief about the comparability, I believe that despite being NCQA accredited, our HMO cannot meet the new HCFA proposed standards.

The second example is the proposed provider participation rules. The Medicare+Choice rule expands the Balanced Budget Act definition of providers who can appeal from only physicians to all health professionals. This rule defines appealable actions so broadly as to include not only network participation decisions, but virtually any change a health plan may make in its medical payment or administrative policies.

In summary, to assure the success of the Medicare+Choice program, we recommend that the Health Care Financing Administration immediately scale back rules that are excessive, drop the requirements that are not mandated by the Balanced Budget Act, and restructure the timeline implementation.

Additionally, we request that Congress reexamine the Medicare+Choice payment rules next year. Blue Cross and Blue Shield plans want the Medicare+Choice program to succeed. The decision to participate will be based on whether we can accept the significant new business risk and the existing financial restraints in order to continue to serve.

Thank you very much.

[The prepared statement of Donald P. Sacco follows:]

PREPARED STATEMENT OF DONALD P. SACCO, PRESIDENT AND CHIEF EXECUTIVE OFFICER, REGENCE BLUE CROSS AND BLUE SHIELD OF OREGON

Chairman Bilirakis and members of the subcommittee, I am Donald P. Sacco, President and CEO of Regence Blue Cross and Blue Shield of Oregon. I am testifying today on behalf of the Blue Cross and Blue Shield Association (BCBSA), which represents 54 independent Blue Cross and Blue Shield Plans across the country that provide health coverage to 69 million Americans. I thank you for the opportunity to express our views about the implementation of the Medicare+Choice program.

Blue Cross and Blue Shield Plans have a long history of involvement in Medicare, and their unparalleled community roots make them uniquely qualified partners to deliver health services to Medicare beneficiaries. Collectively, Blue Cross and Blue Shield Plans provide Medicare HMO coverage to more than 750,000 Medicare beneficiaries, making the Blue Cross and Blue Shield system the second largest Medicare HMO provider in the country.

Regence Blue Cross and Blue Shield of Oregon provides health coverage to over 1 million Oregonians. Our Plan has had a Medicare HMO contract for the past 13 years. And, today, we provide HMO coverage to 130,000 Medicare beneficiaries through our cost, risk and Medicare supplemental policies. Oregon is one of the states with the highest percentage of enrollment in Medicare HMOs. In fact, in Portland, enrollment in Medicare HMOs far exceeds enrollment in the traditional Medicare program.

In creating Medicare+Choice under the Balanced Budget Act of 1997 (BBA), Congress sought to expand significantly the numbers and types of private health plan options that are available to Medicare beneficiaries.

The Blue Cross and Blue Shield Association strongly supported enactment of Medicare+Choice. We agreed with Congress that the Medicare program—more than 30 years after its inception—needed to be modernized. BCBSA believed that Medicare beneficiaries and the program itself would benefit if the health coverage options available to beneficiaries more closely resembled the options available in the private marketplace.

However, the Blue Cross and Blue Shield System is deeply concerned that the interim final rule implementing Medicare+Choice runs counter the congressional goal of giving Medicare beneficiaries greater choice among private health plans.

Because these regulations contain overly expansive interpretations of many BBA provisions and new requirements not explicitly authorized by the BBA, we are concerned that Medicare beneficiaries are likely to have fewer, not expanded, health plan options.

The overly expansive requirements—especially when combined with the problem that many of the program requirements need clarification or will not be available until after contracts for the year are signed—will increase the business risks and costs for existing and potential contractors. Importantly:

- To absorb the costs of compliance with the new regulations, contractors that join in the Medicare+Choice program will have to scale back any extra benefits that many Medicare HMO enrollees may now enjoy.
- Other contractors may scale back their areas of service, or ultimately avoid the program altogether, because of the new costly and burdensome rules.

Any organization that wants to participate in the new Medicare+Choice program must sign a contract in early November that will commit it to participation for all of 1999; there are no provisions for terminating participation during the year. Before signing the contract an organization must have confidence that it can comply with all applicable regulations and program requirements, including those issued after the contract is signed, without incurring undue business risks or costs.

The business risks in the implementing regulation are new and unprecedented. Because the regulations are so expansive and because contractors will not know the full extent of the requirements until after contracts are signed, any potential Medicare+Choice plan would have to seriously consider the risk of unintentionally failing to comply with every requirement. The consequences—because of the new penalties—would be severe.

To assure a successful program, the implementing regulations should have been written to encourage, not discourage, participation. Instead, the regulations unnecessarily add to concerns that already existed about participation in the program because of several payment issues, including the 1999 payment cap and the scheduled introduction of the new risk adjustment methodology.

We have met with HCFA to discuss our concerns and have filed our written comments on the regulations. While the agency appears receptive to some of our concerns, we need quick action to revise the interim regulation to assure that, at a minimum, current contractors have an incentive to participate in the new program.

We have told HCFA that in order to increase the chances of success of the Medicare+Choice program, they should:

- *Immediately* scale back provisions of the regulations that are overly expansive and drop provisions that were not required by the BBA.
- Allow plans to update their 1999 ACRs.

We are also urging that Congress reexamine Medicare+Choice payment rules.

I. HCFA SHOULD IMMEDIATELY SCALE BACK PROVISIONS OF THE REGULATIONS THAT ARE OVERLY EXPANSIVE AND DROP THOSE THAT ARE NOT MANDATED

While the goal of Medicare+Choice was to encourage new types of coverage options, the regulations simply will not work for most new categories of plans, such as Preferred Provider Organizations (PPOs), Medical Savings Accounts (MSAs) and Private Fee-for-Service Plans. The regulations should be revised to account for the different issues presented by these categories of plans. Also, we believe that the issue of adding additional coverage options under Medicare+Choice should be revisited next year by Congress.

Most importantly, we are concerned that some current Medicare risk contractors will be unable to provide HMO coverage to Medicare beneficiaries under the new Medicare+Choice program. This concern has become our top priority.

As noted, before an organization can commit to complying with all applicable regulations and program requirements in early November, they must have confidence that the regulations will not impose unreasonably high business risks. Just last week, BCBSA sent its official comment letter to HCFA on the interim final regulations. BCBSA is urging that HCFA immediately—before the contracts must be signed in November—scale back the rule's most expansive provisions and drop new requirements not mandated by the BBA.

The key problematic provisions include:

Quality standards:

While Congress intended that HCFA develop assurances for the quality of care provided to beneficiaries, the rule's standards—based on HCFA's Quality Improvement System for Managed Care (QISMC)—go beyond both the statute and leading private sector standards (e.g., National Committee for Quality Assurance).

QISMC was an effort predating the BBA to craft a single set of quality standards for Medicare and Medicaid HMOs. This approach is not compatible with today's prevailing philosophy of quality improvement—flexible goals will inspire change and risk-taking. Rigid, arbitrary numerical standards will stifle innovation and, effectively, mandate plan design.

We understand that HCFA intends to release a new QISMC document in the near future. However, given that the document released earlier this year was the only document available at the time we submitted our comments to HCFA, we identified the following problems:

- *Minimum Performance Levels.* HCFA has already indicated that its standard reporting measures will include so-called "effectiveness of care" measures from HEDIS, as well as utilization measures. Plans will have to meet a specific numerical level of performance on each standard. But, no private accreditation program requires plans to meet minimum levels of performance. Achieving a specific numerical standard is a problem for HMOs and is a problem with respect to encouraging new types of health plans; PPOs have a very limited capability to produce valid HEDIS data and influence physicians' practice patterns.
- *Performance Improvement Projects.* Such improvement could include, for example, a 10 percent reduction in negative outcomes in significant aspects of clinical care and nonclinical care areas. These are extremely aggressive benchmarks. HCFA should consider the approach taken by NCQA, which requires that health plans provide "meaningful" evidence that they are working effectively to improve clinical care and service. "Has an improvement resulted in a better outcome for the enrolled population?" and "Was it attributable to the strength, duration and quality of the health plan's actions?" are more appropriate standards.

Requirements for minimum performance and improvement of health conditions based on numerical standards are simply not compatible with the current, relatively undeveloped state of performance measurement. Any plan, for example, might fall short of a specific numerical standard because of random events beyond its control (e.g., unfavorable risk selection relative to other plans, an increase in the underlying prevalence of a disease or changing socio-economic conditions). Plans with relatively small enrollments would be especially disadvantaged. The penalties for failure to meet the numerical standards are severe. Failure to meet these rigid standards may lead to penalties such as sanctions or loss of contract.

From a larger perspective, HCFA should step back from attempting to develop a unique quality assurance system for Medicare+Choice and rely much more heavily on the systems used in the private sector. First, HCFA will have great difficulty assembling and maintaining the expertise required to operate a unique quality assurance system and, second, it does not make sense for plans to run a separate quality

assurance system for the Medicare business. This is a substantial disincentive to participate in the program.

The Blue Cross and Blue Shield Association has urged HCFA to:

- Restructure QISMC to conform with leading private sector approaches for performance measurement.
- At a minimum, delay the requirement that plans meet a minimum performance levels until 2001.
- Not tie contract renewal or other sanctions to numerical standards.
- Take into account differences in health plan types and sizes when comparing data or setting standards.

Participation Procedures for Providers:

The BBA established limited appeal rights specially for physicians. The regulation, however, takes a clear and narrow requirement in the BBA and expands it significantly in several respects:

- The regulation goes well beyond the statue by extending the appeal rights to all non-physician providers. This will be a significant cost for plans and not benefit beneficiaries since there are already appropriate requirements for access.
- BCBSA is extremely concerned that the rule requires plans to respond to appeals on virtually any change of organizational or medical policy, and not just decisions on excluding physicians from a network. For example, this requirement could be construed to allow providers to appeal changes in quality improvement programs.
- Under the rule, each provider that asks to be included in the network must receive a chance to appeal a negative decision. It is not uncommon for health plans to receive numerous calls each day from providers seeking to join their networks, most of which they might turn down because their networks meet all applicable access and availability standards. If Medicare+Choice contractors cannot deny participation without triggering the participation procedures (including the appeals process), they will invariably be driven towards an "any willing provider" approach.
- For each health care professional who appeals a termination decision, the Medicare+Choice contractor must convene a panel, and a majority of the panel's members must be peers of the affected professional. This requirement will greatly raise administrative burdens and costs. Depending on the number of appeals, Medicare+Choice organization's might have to convene dozens of separate hearing panels at any one time.

I would note that these requirements affect an organization's ability to manage costs not only in the Medicare program but also in its private business. Health plans do not generally have separate provider networks for their Medicare business and their private business.

HCFA's regulation in this sensitive area sets the stage for needless and costly administrative actions and litigation which the legislative language attempted to avoid. HCFA's regulations in this area should be amended to strictly adhere to the legislative language.

The Blue Cross and Blue Shield Association has urged HCFA to return to the definitions set in the BBA that would:

- Limit participation rules to physicians only.
- Limit the definition of participation rules and appeals rights to network exclusion decisions.
- Drop the requirement for appeal of denials when a network has sufficient numbers of physicians to meet enrollees' health care needs.
- Eliminate the mandate for a hearing.

Access to Services:

There are several important issues in the rules regarding access to services:

- The requirement for a one-hour time limit for approving emergency room post-stabilization services is problematic. A Medicare+Choice organization may need more than one hour to obtain the information necessary to authorize or arrange for the patient's post-stabilization care. Also, we are concerned that the rule requires the adoption of a potentially lengthy and costly plan of treatment without the normal consultative process between the provider and the health plan.
- The rule contains requirements fox administering health assessments for all enrollees. BCBSA concurs that it is important to contact new enrollees. BCBSA recommends that this provision be interpreted to allow "screening" of a type that would allow voice or mail contact with new enrollees. We are concerned that the term "health assessment" implies a much more comprehensive evalua-

tion of each patient than is necessary. In addition, health screenings may not be necessary for individuals who have a history with the particular plan or a plan network provider. BCBSA also urges that the assessment requirement not be required for age-ins or patients under the care of network providers prior to enrollment in the Plan. Finally, we would like to work with HCFA to clarify that an expectation of 100 percent compliance within 90 days is not an achievable standards; the standard should be an attempt at 100 percent compliance.

We have asked HCFA to:

- Lengthen approval of post-stabilization care timeframes beyond one hour and provide for a more reasonable process regarding a plan of treatment.
- Allow plans to conduct health screenings (by telephone or mail), rather than health assessments. Also, HCFA should evaluate performance on this requirement by assuring that plans made a good faith effort to contact all new enrollees, instead of requiring 100 percent compliance for all new patients. Some patients may simply be unwilling to provide this personal information.

Intermediate Sanctions:

Although Congress intended that intermediate sanctions be used as an intermediate step before terminating a contract, the rule spells out a plethora of "offenses" that can trigger sanctions. Some of the penalties (e.g., suspension of payment for all enrollees) are potentially worse than termination from the program.

Such provisions will serve only to deter health plans from participating in Medicare+Choice. We are particularly concerned about the departure from normal legal procedure: the rule allows plans only 15 days to respond after receiving a HCFA notice and a plan is then required to "provide evidence that it has not committed an act or failed to comply" with specified requirements; the burden of proof is shifted to the plan to demonstrate compliance rather than requiring the accuser to demonstrate a violation; the rule does not appear to require any showing of culpability; and in the case of sanctions such as suspension of payment, there is no hearing requirement, but merely a review of the evidence by a HCFA official.

We have urged HCFA to:

- Ensure due process prior to imposing sanctions and allow up to 30 days for plans to respond.
- Show "intent" before applying sanctions.
- Adhere to the BBA provision that allows payment suspension only for new enrollees.

Reconsideration and Appeals Process:

The regulations provide timeframes for plan responses to emergency and non-expedited (routine) requests for services and appeals. The standard for non-expedited requests for service and appeals is for the plan to respond within 14 days or "as expeditiously as the enrollee's health condition requires." This language, in effect, is so vague that the 14 day standard becomes meaningless with the risk of substantially raising plan costs.

We have urged HCFA to drop the vague language.

Attestations:

The regulation incorporates an entirely new requirement—not required by BBA—that health plan CEOs or CFOs certify 100 percent accuracy of the encounter and enrollment data sent to HCFA. Attestations are also required—as in the past—for calculation of the ACR (adjusted community rate). Penalties for inaccurate submissions would include civil and criminal actions. The requirements for attestation on enrollment and encounter data presents are an unacceptable level of risk for organizations and executives. Requiring 100 percent accuracy for this information is unworkable. For example, much of the encounter data is beyond the contract of plans, as it is submitted by providers. Moreover, new certification requirements run counter to Federal contract law discouraging such certifications.

We are urging HCFA to drop the requirement for attestation of encounter and enrollment data. At a minimum, HCFA should enable plans to adopt a "best faith" effort that data are accurate for all three attestations.

Mandatory compliance program:

We believe that the requirement for a mandatory compliance program is unprecedented. The Packard Commission (created by President Reagan) rejected the notion of mandatory compliance programs for the defense industry and instead recommended voluntary compliance programs.

Among the most troubling aspects of a mandatory program is that Medicare+Choice must report any possible violation before it is even investigated,

possibly even early identification of suspicious beneficiary or physician behavior in routine screening programs. Importantly, such reporting does not appear to allow plans the ability to self-correct any problem areas. Also problematic is that mandatory compliance programs require the corporation to waive its attorney-client privilege.

We are urging HCFA to drop this mandatory compliance plan and instead to follow the voluntary models for compliance programs used for contractors in other industries, including for defense contractors and other Medicare providers.

II. HCFA SHOULD ALLOW PLANS TO UPDATE THEIR ACRS

We are urging HCFA to allow plans to update immediately the 1999 ACR filings that were made in May—almost 2 months before the Medicare+Choice regulations were released. This is important in order to allow plans to reflect the significant new costs resulting from the new regulations.

III. MEDICARE+CHOICE PAYMENT RULES

The promise of the Medicare+Choice program will not be fulfilled if health plans are faced with the proposed regulations and inadequate funding. A combination of the two places health plans in an untenable situation of increased and significant business risk. Congress must assure adequate and predictable payments to health plans. Inadequate payments are likely to discourage new health plans from participating in the Medicare program, but they are also forcing current participants to exit the market or scale back their participation in certain areas.

Congress's intent in revising Medicare HMO payment rates in the BBA was, in part, to reduce the significant variation in payment rates made to HMOs across the country. The formula change was intended to result in payment increases for areas of the country, like Oregon, that were being paid less than the national average. However, as of this date, sufficient payment increases have not been made available for many areas of the country. In addition, payments to all plans have been capped at an annual 2 percent increase, which simply isn't sufficient to keep pace the with expected increases in medical costs. Low-cost states like Oregon were relying on substantially increased payments to provide equitable and reasonable payment rates. We encourage Congress to revisit the Medicare+Choice payment formula.

The implementation of a new risk adjustment mechanism for the year 2000 is likely to cause even greater problems for health plans in the future. Beginning in the year 2000, the payments to Medicare+Choice plans will be adjusted for the health risk of their members which will very likely result in significant payment reductions for certain health plans. The uncertainty created by the risk adjuster fails to provide the stable rates that health plans need to enter a new market. This uncertainty could further limit the choices available to beneficiaries by discouraging health plans from participating in Medicare+Choice.

Blue Cross and Blue Shield Plans also have serious concerns about the methodology HCFA is pursuing in developing this new risk adjustment formula. HCFA's current plans are to base this formula on hospital inpatient data only, which does not adequately reflect the costs of outpatient care provided to the chronically ill and could provide perverse incentives for hospitalization.

We believe that Congress should revisit the Medicare+Choice payment formula and should, at a minimum, delay the imposition of the risk adjuster to ensure that a variety of health plans will be available to Medicare beneficiaries in all areas of the country.

IV. CONCLUSION

Given the level of concern among existing risk contractors, BCBSA is urging HCFA to move quickly to drop or delay until the year 2000 any sections of the regulations that are not mandated by BBA and to scale back the scope of the mandated provisions before contracts are sent out in November.

In addition, we are urging HCFA to allow an update to the ACR filings that were made in May. This is necessary to allow Plans to reflect the significant new costs resulting from the new regulations. I would note, however, that it should be clear that the decision of current Blue Cross and Blue Shield risk contractors to participate in the new Medicare+Choice program will be based not just on the ability to reflect any new costs in the ACR but, more fundamentally, on whether the major new business risks—as outlined in my testimony—are determined to be acceptable.

Despite the fact that most existing contractors have filed the October 1 supplemental applications, many Plans have deep concerns about participating in the program without the modifications that I have mentioned. It is our belief that the Octo-

ber 1 filing has not committed Plans to the new program; such a commitment will only be made upon signing the new contracts, which are expected in November.

The Blue Cross and Blue Shield System hopes to continue a dialogue with HCFA over the next month and a half to ensure that the Medicare+Choice contracts reflect our concerns and solutions.

Finally, we urge Congress to work with the industry to explore appropriate legislative revisions to the Medicare+Choice payment methodology.

We look forward to working with the subcommittee to make sure that Medicare+Choice is a successful program. Thank you for giving me the opportunity to speak with you on this important issue.

Mr. BILIRAKIS. Thank you, Mr. Sacco. Mr. Bradley.

STATEMENT OF BRUCE E. BRADLEY

Mr. BRADLEY. Good afternoon, Mr. Chairman. I am Bruce Bradley, Director of Managed Care Plans on the General Motors Health Care Initiatives Team, and I very much appreciate the invitation to be here.

General Motors' core strategy in its health care initiatives work is really based on the premise that driving quality improvement gets at the root cause of many of our health care cost problems and others.

I also wanted to mention that I am a member of the planning committee for the National Forum on Health Care Quality Measurement and Reporting, as well as have been involved with HEDIS since its very beginning. I am on NCQA, HEDIS Committee on Performance Measurement, plus a member of the FACCT board, and I am very fortunate to work for an individual who is co-chairing the Competitive Pricing Advisory Committee, which came from the Balanced Budget Act, for Medicare.

The reason I mention that is that I want to underscore that GM has a commitment, given the tremendous amount of time we are committing to this, to really working together with multiple constituencies to drive improvement in a common way. I think it's terribly important that we do that.

Just briefly, General Motors spends—we have about 1.5 million people that we provide health care coverage for at a cost of about $4.8 billion per year. Of that, 381,000 are Medicare beneficiaries at a cost of approximately $900 million a year. So you can see we have a rather significant interest in this topic.

Today I would like to share with you some of the things we have learned through our participation in a variety of health care improvement efforts, and they are all listed pretty much in my written statement. I would also like to talk some about our work with our retirees to help them with the Medicare+Choice program.

First, we believe it is crucial for the public and private sectors and purchasers to work very well together and especially work with our health plans. This is happening; it is taking place through all these other activities, and I think we all need to recognize that the real solutions are going to come in these partnerships.

Second, I also want to mention that GM requires as a condition of doing business, that HMO's be NCQA accredited, that they report HEDIS information, that they work toward meeting a rather rigorous set of performance standards which were mentioned earlier, and that they participate in extensive quality improvement programs and work with us in those areas that we identify a need.

We all need to be very sensitive and flexible as we go through that process and really understand when health plans have difficulties, to understand and really work with them. It is really not to be a stick, but it is much more focused on working with plans to drive quality improvement.

I recognize that is very difficult when you write regulations and perhaps that is an advantage that we have as an employer. We've got to work effectively with our health plans. We also need to recognize that quality improvement measurement is a very, very difficult task, but it's also exceedingly important. It is particularly difficult because measurement tools and methodology are at a fairly early stage in their development. There is a lack of good clinical information system.

There are different measurement approaches, different issues with respect to definitions, and in some cases—and this is true that there is resistance on the part of some providers, fortunately, not most of our health plans—to being measured and being held accountable. We've got to recognize that and we've got to really remember that we have a consumer here that we need to be very sensitive to.

It's essential that we push the envelope on quality measurement and performance, while at the same time, we've got to recognize that there's quite a burden that's placed on the health plans when there's inconsistent approaches to performance measurement. And so it is a very, very careful balance, and I will speak a bit more about that later.

Third, I appeared before this subcommittee about a year ago and reported on our efforts to use our quality improvement measurements, our quality measurements, and financial incentives to provide incentives for people to enroll and move toward the higher quality health plans, using those measurements that I mentioned earlier.

In fact, the second year that we did this, we saw even more dramatic movement from the poor performing plans to the good performing plans, and again, it's based on a combination of providing consumers with good information, as well as financial incentives.

HCFA, as well as FEHPB, has been involved in a number of quality improvement measurement activities, and their participation has been invaluable. We must do a better job of coordinating our efforts, and I think that is clearly the subject of a lot of the discussion here. And I think we've got to continue to work on doing a better job with that. However, I think tremendous progress is being made and I think we all need to be encouraged to do that.

I have four recommendations that really follow from that. First, the continued participation of government health care purchasers in efforts to increase the efficiency of performance measurement. I think it's really very, very important.

Second, agencies such as AHCPR and the CDC are doing a tremendous amount of good work and research and their efforts need to be supported. Especially in quality improvement, GM has a number of specific projects.

Third—and I'm almost done—the HCFA communications initiatives require a lot of your support for Medicare+Choice. They have an incredibly hard-working, first-rate staff doing a near impossible

job to get the message out in a very complicated program. And it's my belief, looking at the budgetary numbers, that they have not anywhere near the resources that they really need to do this.

And then finally, the HCFA Competitive Pricing Advisory Committee is tackling a very important task to develop the demonstrations to fundamentally change this whole business of using the AAPCC as a method for reimbursement, which is, of course, the core of many of the issues.

They may be making some recommendations to either this committee or the Congress or whatever, and I really urge serious consideration of those. They are super, first-rate people working on that committee with a great deal of thought.

Thank you very much, Mr. Chairman.

[The prepared statement of Bruce E. Bradley follows:]

PREPARED STATEMENT OF BRUCE E. BRADLEY, DIRECTOR, MANAGED CARE PLANS, GENERAL MOTORS CORPORATION

Good morning. I'm Bruce Bradley, Director Managed Care Plans on the General Motors Health Care Initiatives team. My responsibility at GM is to work with managed care health plans that provide services to General Motors employees, retirees and their families, to assure that these organized systems of care meet our quality-based performance expectations and that they strive to continually improve. I am also a member of the Planning Committee for the National Forum on Health Care Quality Measurement and Reporting, created as a result of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Additionally, I am a Trustee of The Foundation for Accountability (FACCT), a member of the NCQA Committee on Performance measurement (responsible for HEDIS), and am currently the President of the Employers Managed Health Care Association (MHCA). Jim Cubbin, Executive Director Health Care Initiatives for General Motors, is Co-chair of the Medicare Competitive Pricing Advisory Committee, which was created in the Balanced Budget Act to help HCFA with a more sensible approach to health plan purchasing. Mr. Cubbin is also a member of the Board of Directors of NCQA. Our involvement in these activities is based on the premise that those of us with responsibility for purchasing health care and assuring that consumers needs are met, must work together to accomplish our objectives in the most efficient and effective way possible. Today, I would like to share some of the things we have learned and discuss the importance of public and private purchasers working together in a consistent way to drive accountability for quality on the part of our health plans and providers, including those in the indemnity, or fee-for-service sector.

I would like to start my comments by recognizing the work of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Their Final Report to the President: *Quality First: Better Health Care For All Americans* should be required reading for everyone with responsibility for health care policy and delivery. Health care quality (not managed care per se) is the issue. There is considerable evidence in all sectors of widespread underuse, overuse, misuse and variation in health care services. This must be addressed. Quality performance measurement and accountability needs to be applied in both the managed care and the currently unmanaged and unaccountable fee-for-service sector. The report frames these issues quite well and recommends a number of strategies to improve care. One important provision is the establishment of the Advisory Council for Health Care Quality and the Forum for Health Care Quality Measurement and Reporting. Both are important public and private sector collaboratives. While the development of the Forum is underway and proceeding well, I am concerned that the establishment of the Advisory Council for Health Care Quality, which requires legislative action, may be delayed. A key role of that Council is development of National Aims for improvement. This is an important foundation for all our efforts to develop and implement a consistent quality improvement strategy. I would also like to state that General Motors supports the Consumer Bill of Rights and Responsibilities and has begun to implement its provisions. We will be formally including it in the next version of our HMO expectations document.

General Motors has considerable interest in, and involvement with, the health care system. GM is the nation's largest private sector purchaser of health care, providing health coverage to 1.5 million employees, retirees and their dependents. Our

enrollees live in all 50 states plus the District of Columbia, and receive services through 200 different health plans, 6,000 hospitals, 35,000 pharmacies, and half a million doctors. In 1997, GM's total health care expense was about $4.8 billion, including out-of-pocket costs as a self-insurer, as well as accounting accruals for future costs. This amounted to about $1,200 per vehicle we produced and sold in the United States last year.

Included in above numbers are 381,000 Medicare beneficiaries for whom we provide additional coverage, through either HMOs or supplemental indemnity coverage. We are the largest non-governmental purchaser of coverage for the Medicare population in the country. (GM's 1997 Medicare HMO and indemnity supplemental cost was $900 million.)

As you may recall from my testimony before this committee approximately one year ago, General Motors requires extensive quality reporting from our health plans. We use this information to inform consumers about plan performance and also to determine the monthly contributions for various health plan options for our salaried employees and retirees. The plans that perform best on quality measures cost the employees and retirees the least. This has resulted in significant migration from the poorer-performing plans to the better ones. We also use this information to work with our HMOs on quality improvement expectations and initiatives.

Our focus is to provide uniform, high-quality health care to GM people and to the communities in which they live, while procuring the best value for each dollar spent. We found that in the health care system, as in the manufacturing of motor vehicles, high costs are often a symptom of poor quality. Improving quality lowers real costs. There is accelerating movement toward holding health plans and providers accountable for performance on quality and customer service. Purchasers, both corporate and public (specifically HCFA and the Federal Employees Health Benefits Plan), are rapidly assuming a leadership role to drive quality improvement in our nation's health care system, and we are beginning to see that it is effective. Purchasers are demanding performance measurements on quality and are working together with providers to identify and implement opportunities for improvement.

Measuring performance on quality is a very difficult, expensive and challenging task for health plans and providers. There are many reasons for this, including inadequate clinical information systems, different measurement approaches, sample size of certain populations, mobility of the population, emerging measurement science, definition issues, priority setting, and resistance on the part of some who do not wish to be measured or be held accountable. On the other hand consumers, purchasers, providers and regulators all agree that quality is important and that measurement and reporting are essential tools to drive improvement.

Given the importance as well as the inherent difficulty and complexity of performance measurement and actual use of these measures, it is critical that this be accomplished in the most efficient manner possible. There must be as little burden as possible on the providers without sacrificing valuable information. This means that public and private purchasers must be aligned in our expectations, have similar non-duplicative requirements, and use the same tools and processes to measure and drive quality improvement. Moreover, we must work with the providers and health plans to make even the common processes as efficient as possible. An example of this effort is the work of the NCQA Committee on Performance Measurement on a project to analyze HEDIS reporting to find ways to simplify and reduce the reporting burden without losing content. This is being done with the very valuable input of measurement experts and enlightened health plans who believe in quality performance measurement.

The overriding purpose of these efforts is to create positive behavior change on the part of consumers, purchasers, regulators and providers. Consumers need this information to make intelligent choices about their health plan options. Purchasers need to understand value in order to meet the needs of the consumers they represent. Regulators need to focus on the right things. And providers need information and motivation to improve. In all these scenarios, the informed consumer is the driving force.

I would now like to provide an example of how a quality-based strategy is actually working. The core of GM's managed care strategy is value purchasing. The tools we use to measure value are nationally-accepted scientifically-based performance measures such as HEDIS and the NCQA satisfaction survey, along with our customer-specific information requirements. The following is a brief description of the components of value: Functional outcomes, Effectiveness of care, Satisfaction, Access, Benefit level and Cost. I will then discuss the rationale for each component of the value paradigm along with a description of the measurement tools.

- *Functional outcomes* is a very important component as this is the result of the care provided and the patient's contribution to their own health. In other words

this is the "results." It is also the most difficult to measure. FACCT has developed a series of disease- and population-specific measures which are just now being implemented by some health plans and communities. This includes working with NCQA to have measures included in HEDIS. An example is the diabetes measurement set. As these measures are adopted by health plans and purchasers, and disseminated to consumers, they will assume an increasing importance in health plan evaluation.

- *Effectiveness of care* quality measures include a series of measures in the HEDIS 3.0 data reporting set. Notably, although HEDIS measures are generally process measures, improved performance on a measure is associated with an improved outcome. Health plan site visits, and analysis of detailed responses to a request for information (RFI) based on specific quality performance expectations, provide valuable information on a health plan's actual implementation of its quality programs and processes. NCQA Accreditation is both a quality performance measurement tool which addresses processes to assure effectiveness of care and is a condition of doing business with GM.
- *Patient satisfaction* is also a critical component of the value equation and is rated high in importance by consumers. NCQA and AHCPR have worked together to take the best of their standard satisfaction surveys and have developed a combined instrument which is required of all participating HMOs. We are also having this instrument administered to participants in our PPOs and indemnity plans.
- *Access to care* is also a highly important component of value to consumers. A series of access measures are included in the NCQA satisfaction survey, the GM RFI questionnaire, and the HEDIS measures.
- *Benefit Level* in the HMOs GM offers is significantly greater than in the indemnity plan. This added value is enabled by the greater management of the health plan delivery system.
- *Cost* is the final value component, which includes premium, analysis of health plan internal cost efficiency factors, risk of the population being served, and comparison with indemnity costs in the same service area. This is measured by rate proposals and supporting information provided by the health plans. GM has a sophisticated health care information system, which provides comparative cost analyses of the self-funded indemnity plan in each geographical area served.

All HMOs are scored on each of these components and the scores are combined to arrive at a single rating for each plan. It is important to note that in calculating this plan rating, quality elements are weighed equally with cost under our system. The plan ratings form the foundation of our communications with our employees and retirees. They are also used in determining which plans are offered and the level of contributions for salaried employees and retirees. The significant message is that we provide a strong financial incentive for salaried employees and retirees to select the health plans that perform best on quality. This is a major departure from the traditional premium-based approach which we hope will be adopted by more purchasers.

Along with providing financial incentives to select the quality plans, we also provided our employees and retirees with a consumer guide showing them specific health plan performance ratings on our quality measures. This personalized guide lists each of the health plans for which the individual is eligible, along with the HMOs' "report card" performance on the series of quality measures. This year the guide was developed in collaboration with NCQA, FACCT, Ford and Chrysler, the UAW, State of Michigan and the Greater Detroit Area Health Council. We have established a GM-specific world wide web site with the HMO performance information as part of our 1999 enrollment communications process. The guide and the web site also explain the importance of quality measurement and provide a description of each measure. We have also taken advantage of these communication vehicles to provide other health care consumer information.

Two years of experience with this strategy achieved significant migration toward the better-performing health plans. Enrollment in the top-rated plans (our benchmark HMOs) grew by 30 percent. The strong plans gained 28 percent and the good plans grew by 19 percent. Average HMOs gained 11 percent, the fair plans lost 23 percent and the poor plans lost 82 percent of their GM population. Part of the 82 percent loss of the poor plans is attributed to our dropping or freezing enrollment in several of these HMOs.

We have achieved exactly what we had expected, behavioral change directly linked to performance of the health plans on the basis of quality, largely driven through a combination of financial incentives (monthly contributions) and quality performance information. We also provide this information to the leadership of our

HMOs with the expectation that they will use it for quality improvement. Medical directors are generally very receptive because it gives them the support of the customer as they work with their medical staffs to implement improvement. The data assists them in developing quality improvement initiatives and in setting and monitoring their performance targets and priorities to meet customer expectations.

At the local level, we are working with our unions, other businesses, providers, and state and federal government agencies (including HCFA and CDC), to improve care in the communities where our employees and retirees live and work. In a number of communities, General Motors represents as much as 60 percent of the lives of the community, so focusing solely on improving the health care of our own employees will not solve the problem. We have to play a major role in raising the standards for entire communities by working with these other stake holders to hold the providers accountable and to provide tools, such as data and support, to help them. That is a very important direction that all purchasers—corporations, community coalitions, Medicare, Medicaid, the Office Personnel Management, and others—should be taking.

Our experience demonstrates that health care purchasers that have a clear idea of their quality goals and objective measures of progress toward these goals, and who are willing to work with health plans in achieving them, are effective in improving the quality and delivery of health care services. Through the collection and dissemination of outcomes, service and cost data, the marketplace effectively holds health care providers accountable for continuous quality improvement. The continued participation of HCFA, the Federal Employees Health Benefits Program and others in these efforts is essential. These purchasers have the capacity to leverage the important role of the consumer through the use of information for consumer decision making. In addition, as the largest purchaser of health care services in the country, the federal government is a pivotal player in leading health plans down the road to implementation of quality improvement measures. Also critically important are the state Medicaid programs. Some state Medicaid programs are very actively working with the private sector to develop and apply quality performance measures, while others need to be encouraged to do more.

HCFA, FEHPB and some states, along with many private purchasers such as GM, require HMOs to submit HEDIS data as a part of their standard measurement set, have established minimum standards and expectations, and require evidence of quality improvement. In addition, GM, some states, and a number of other employers, require NCQA accreditation of HMOs as a condition of doing business. We believe that such collaborative and consistent efforts will effectively produce health care quality improvements through accountability in the market place. I am concerned, however, that we all need to do a better job of coordinating our efforts to minimize the burden on health plans.

In closing, I would like to make four recommendations:

- First, the collaborative efforts of government purchasers to increase the efficiency of performance measurement and reporting deserve your support. By reducing the administrative burden on health plans we can enable them to focus more attention on actual quality improvement.
- Second, AHCPR, CDC and others are doing very important research work to drive quality improvement in health care. These agencies have worked closely with the private sector and their contribution is invaluable. I urge your continued support for their research agenda.
- Third, the HCFA communications initiatives concerning the Medicare+Choice program need your support as well. This program is exceedingly complex and confusing to seniors, and HCFA has a budget of only $94 million to communicate with 39 million beneficiaries. This is less than $2.50 per beneficiary. GM, along with other employers, has been working with the HCFA staff in the Office of Beneficiary Services to coordinate our messages and to help each other. I have personally worked with this office and can tell you that it is an incredibly dedicated, hard working group of people facing an extremely challenging situation. If they are going to succeed they need your support and adequate resources. Having been personally involved in GM's efforts to inform our own retirees about the Medicare+Choice program, I know how difficult their assignment is.
- Fourth, and finally, the HCFA competitive pricing advisory committee is tackling a very important task to develop the demonstration for improving the HMO pricing and contracting process. I have observed their work, and believe is proceeding well. As result of their deliberations they may be making some recommendations. If they do, I would urge the Congress to respond favorably.

HCFA and other federal agencies such as the Federal Employees Health Benefit's Plan with the help of CDC, AHCPR, and others in collaboration with the private sector, can move the public policy agenda forward through this market strategy. As

is very clear in the report of the President's Advisory Commission, quality is very high on the agenda. We are pleased that so much has been achieved this past year and appreciate your support for the continuation of this valuable partnership.

Mr. BILIRAKIS. Thank you, Mr. Bradley. I'm sure HCFA is very happy to hear some of your comments, too, because there's no question that they are all under the gun.

This may not go too specifically to the problem, but before we get into that, just very quickly, Mr. Gradison, do your member companies offer medical savings accounts?

Mr. GRADISON. Yes, we have some members that do; not very many.

Mr. BILIRAKIS. Not very many. Any reason for that?

Mr. GRADISON. Mr. Chairman, I think a lot of companies are addressing that issue rather slowly, wanting to assess what that market will look like before they enter it. I don't think it's possible at this stage to judge really what its future is going to be until there is more experience.

Mr. BILIRAKIS. Thank you. A fundamental question to all of you—and I don't have much time, so your responses should be brief. Last year, the health plan community was strongly supportive, and I realize you weren't necessarily strongly supportive of every area, but of the Medicare+Choice program, certainly in general, which Congress enacted in BBA 97. I guess your support was possible at least in part because you believed that the BBA established a regulatory environment that would not impose unreasonable burdens on plans or restrict their ability to deliver high quality, cost-effective health care services.

You have all basically testified, or most of you have, to the effect that regulations are a big problem. You have talked about inadequate payment rates. You know, we tried after so many hours and deliberations and meetings with groups and with you all to come up with something to save the Medicare program and at the same time to offer additional benefits and additional options to beneficiaries.

Where are we today? Should we go back to the payment rates that we had previously, which means backing off? Back in the old days before BBA 97, I don't know that there were too many complaints from the plans regarding inadequate payment rates, other than maybe the rural areas.

On the other hand, we heard almost invariable the publicity of a particular CEO with a payment plan and fantastic salaries. I thought that was pretty darn poor timing. Anyhow, I guess I am asking you Ms. Riley to expand upon your statement, but be very brief. It can be through Ms. Ignagni, just very quickly.

Ms. RILEY. I think you have heard uniform agreement here that the concepts in the Balanced Budget Act, creating affordable choices for seniors, creating a more predictable payment mechanism for health plans, creating an environment where we would be able to make business plans that could be carried out over a 3, 4, 5, 6-year period of time was what was at the base of the support, certainly from my plan and organizations like my plan.

When we saw what came out of the megareg, which was kind of the devil is in the details, and now this is the cookbook that you

will have to operate under, somewhere between concept and implementation, there seems to have been a disconnect.

And I think perhaps the lesson that we could learn from this is between concept and rulemaking, perhaps engaging the operations people from the industry to say, how is this going to play out, how will this look once it's implemented. That might be a recommendation that we make in the future, that somehow before we get to the cookbook phase, that we engage the industry, the people who are actually doing the day-to-day work, to engage them in the design of the implementation of the program, especially something that is this big and this historic.

Mr. BILIRAKIS. Would you say more emphasis on that than the inadequate payment rates?

Ms. RILEY. I think our second disappointment, obviously, was not implementing the blend. And certainly, as we were, all of us, Congress, senior groups, the industry, everybody, looking at how can we make this program work for everyone, all of the formula components that were in the BBA, the blend, the 2 percent update, the floor, those things, we felt, all had to be implemented in order for it to work.

And the fact that the blend has not happened has been a big disappointment.

Mr. BILIRAKIS. Well, my time has expired. I don't want to preclude any of you from having an opportunity to comment, but I want it be more brief, if you can. Mr. Gradison.

Mr. GRADISON. Mr. Chairman, I'd like to put this in the perspective in which I see it. As I read the numbers, roughly 95 percent of those now covered by risk contracts are not going to be impacted by the withdrawal from certain counties and certain markets.

Now, that's not to minimize the impact on those 300,000 or so folks. But to put it in perspective, it seems to me the next step is to go back to those that have dropped out and ask them why. They'll tell you. You've gotten some information here. Sometimes it's price, sometimes it's that they weren't able to develop a sufficiently large market share to justify staying in the market.

But I think there is a lot more information out there that can be gathered rather than, frankly, guessing as to how much of it is price and how much of it may be other factors.

Finally, looking off in the long run, my personal opinion is that you have an impossible situation and so does HCFA, continuing to run this program on a basis of administered pricing. I don't think there are people or computers smart enough to do it that way. In the long run, if you are going to follow the private sector model, you are going to have to do it by some form of competitive bidding.

Mr. BILIRAKIS. Thank you. Mr. Sacco.

Mr. SACCO Mr. Chairman, I think the real issue, in terms of how many people will stay in and how many people will exit, will be faced in November when contracts are let for those applications. So we really don't know the full magnitude yet.

Mr. BILIRAKIS. Of your 54 plans, how many have withdrawn from the Medicare+Choice program?

Mr. SACCO I am aware of two that have made the decision to withdraw. I am aware of one that has basically withdrawn its application to begin a program.

Mr. BILIRAKIS. Thanks.

Mr. SACCO From my perspective, it's the risk of the compliance of regulations where one, I believe I cannot comply with some; two, I believe I should not comply with others; and three, I believe I don't have adequate time to comply with those with which we have no quarrel.

When I look at that against the economic risk that we all have been taking for years in the low payment area, I feel that I have a real issue about jeopardizing our company.

Mr. BILIRAKIS. Thank you. Mr. Bradley, briefly, sir.

Mr. BRADLEY. I would just like to, again, underscore the importance of the work of the CPAC, Competitive Pricing Advisory Committee. Again, we have to go after solutions. We've not had a major impact at GM largely because we have a backup plan; we can offer other wraparound arrangements. That's the good news. The bad news is that they are very costly.

So it is important, but it takes real good work. If this were a simple problem, we would already have an answer. And that's why the work of some of these bodies is very important.

Mr. BILIRAKIS. Ms. Ignagni, a very brief summary.

Ms. IGNAGNI. Yes, Mr. Chairman, I will be uncharacteristically brief. I think essentially what you have laid down in the BBA is a principle of choice. To achieve that, you have to look at three other principles. One is balance in regulation and compliance on the managed care, Medicare+Choice, and the fee-for-service side, traditional program. The second is balance in the rate of increase on the managed care Plus Choice side, as well as the traditional program. And the third is the concept of predictability and consistency.

I see the problems getting worse, not better, so I am delighted you are having this hearing today and look forward to participating.

Mr. BILIRAKIS. Thank you. I appreciate the committee's indulgence. Mr. Brown, to inquire.

Mr. BROWN. Thank you, Mr. Chairman. Ms. Riley, several of us have talked in the last hour or so, about overpayments to plans. I would like to run through them and ask you some questions.

Overpayments due to BBA changes that removed HCFA's ability to recover overpayments when health care inflation is lower than expected: $800 million in 1997, $8 billion over 5 years, $31 billion over 10 years, Congressional Budget Office numbers.

Overpayments due to lack of risk adjustment: 5 to 6 percent overpayment to HMO's per beneficiary enrolled, from the Physician Payment Review Commission, now MedPAC, 1996 annual report.

Overpayments due to inflation of Medicare share of plan administrative costs: more than $1 billion annually, coming from HHS Office of Inspector General, July of this year.

Overpayments due to inclusion of fraud, waste, and abuse dollars from FFS payments: 7 percent annual overpayment, September HHS Office of Inspector General report, September of this year.

Are they right?

Ms. RILEY. I am going to respond to that just briefly, and then I want to turn it over to Karen to follow up with that. When I look at this at a local market level and I look at the capitated payment

rate that we receive from Medicare, which I take about a 9.5 percent off the top for administrative expenses. And then I turn around and I capitate clinics to provide services, and those clinics are telling me today that they can no longer provide Medicare Part A and B services with the capitated amount.

And I manage their pool balances and I know they are right, I would say to you that there are, in my market place, there are not overpayments. And I think Karen will talk to you about, in general, the industry's reaction to some of these numbers that we are hearing that we think are just incredible.

Ms. IGNAGNI. I think essentially Ms. Riley is right in her conclusion. But I want to amplify it by saying that there have been a lot of hypotheses about whether we are overpaid or not, whether we are treating well people rather than sick people, et cetera. And I think it is incumbent upon us in the industry to provide more of the data that you need to fully evaluate that.

I view this issue as being reduced to the status of name-calling now. We need to——

Mr. BROWN. Wait, wait, wait. Status of name-calling? These are government reports from Congressional Budget Office, from MedPAC, from HHS, and you are all going to sit up here and say it's name-calling, that there is not much basis in fact. These are not witch hunts; these are very specific dollar figures. They are large amounts of money.

Yet Ms. Ignagni, in your letter in late September to Ms. Minn deParle, you mention you want some limited changes that member health plans would like. Yet you are complaining about the dollar figures when there are these kinds of overpayments, and you are only asking for limited changes.

Ms. IGNAGNI. Mr. Brown, as you know, the Inspector General report and many of the other reports have arrived at a managed care estimate of so-called overpayments based on their analysis of what's been going on in fee-for-service. I think that, with due respect, we need to step back and get our hands fully around what this means, what the implications are.

What plans are saying in making their announcements yesterday and today and prior to that, they are saying that there is not enough to cover the cost of treating beneficiaries, the expectations on the compliance side, and to compensate providers. This is a serious matter that is only going to get worse.

Mr. BROWN. Not to mention the huge marketing costs and the huge executive salaries that HMO's are paying—the kinds of things that health care dollars are going out of the health care system to fund nonpatient care.

Let me narrow it to the last of the four I mentioned, from the HHS Inspector General report of September. Overpayments due to inclusion of fraud, waste, and abuse dollars from FFS payments, 7 percent annual overpayment. One of the things that managed care has been telling us for 10 years—my 6 years on the committee, but earlier than that—is that managed care plans can better manage and therefore, avoid such fraud, waste, and abuse. HHS Inspector General said there is a 7-percent annual overpayment because you are paid based on fraud, waste, and abuse estimates, again by the Inspector General, in Medicare fee-for-service.

So you are saying, on the one hand, that we can manage so much better than Medicare fee-for-service does because we are the private sector and we wring out every dollar and we don't waste, in spite of our executive salaries, marketing, etc. We can do all that.

Yet you are getting paid on the amount of Medicare fraud, waste, and abuse, and then you are saying you are not overpaid.

Ms. IGNAGNI. Let me read from the Inspector General's report of September 1998, a sentence which I think makes this point that suggests it is far more complicated than I think we are having an opportunity to discuss.

The Inspector General says, and I quote, "The managed care organization's management had a closer, more hands-on opportunity to control the integrity of the health care services they pay for using the managed care funds, the Medicare MCO funds." And it goes on to talk about the unique aspects in managed care, which actually do a better job on the quality side, on the side of wringing out fraud and abuse.

We are very much anxious to work with the government to achieve these objectives. The problem is, getting back to the overpayment issue, is that many of the hypotheses have relied on old data reflecting early experience in the program.

And the behavior over the last several days demonstrates in very compelling fashion that, in fact, we have reached a very, very different time in this program in terms of adequacy of payment. And it's time to take a hard and serious look at that. That's the point I'm making to you. We also want to participate with you in getting your hands around the numbers and the situation fully and completely, and we pledge our willingness and interest in doing that.

Mr. BROWN. Mr. Chairman, could I have one followup question. So let me understand this. You manage waste, fraud, and abuse, eliminate waste, fraud, and abuse better than traditional fee-for-service, correct?

Ms. IGNAGNI. That's what the Inspector General says.

Mr. BROWN. You claim that, also? Yes or no? Yes?

Ms. IGNAGNI. That's what the Inspector General says.

Mr. BROWN. And do you claim that, too, that you prevent fraud, waste, and abuse better than fee-for-service?

Ms. IGNAGNI. I think what we do is—there is compelling evidence to suggest that we are the only mechanisms presently that can be, and are, in fact, held accountable for what is going on in the system.

We've had several hours of discussion about QISMC and quality on the Medicare+Choice side. There are no similar provisions, as you know, in the traditional Medicare program.

Mr. BROWN. Can you tell me yes or no? Can you claim that you manage and eliminate waste, fraud and abuse as a managed care industry for profit—the managed care industry eliminates waste, fraud, and abuse better than does Medicare fee-for-service?

Ms. IGNAGNI. If you believe that fraud, waste, and abuse and the alternative to that is high quality, accountability, the answer is yes.

Mr. BROWN. Yet you should be paid based on the amount of fraud, waste, and abuse in Medicare fee-for-service, while yours is lower.

Ms. IGNAGNI. No, sir. Actually, I never said that, and I wouldn't conclude that or have the temerity to suggest that. What I am saying, however, is that provider payments in local markets, whether we are talking about a hospital down the street in Washington, DC, particular physicians or physician group practices all around the country, they are based on what they perceive to be their costs. We pay their costs.

What our providers are saying to us around the country now and in many cases is actually responsible for many plans leaving the Medicare+Choice program or not participating in it, because the providers are saying it's not worth it for us to participate with you in this program. We would prefer to be back in the traditional Medicare fee-for-service program.

I am suggesting, with all due respect, that that is a situation that I know you are going to want to get your hands on and that this is not as simple as yes or no, black or white, and we have recognized that and we want to work with you. That's what I am saying.

Mr. BROWN. Thank you.

Mr. BILIRAKIS. Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman. First, I want to say to Mr. Gradison that I respect the integrity that you served with here in Congress and also in your current job. In light of the fact that those associated with the HMO industry have an esteem and prestige profile about as high as politicians these days, you must feel a little bit like Mike McCurry, and I wish you the best in terms of your future endeavors.

And I guess I would also have to say that I very much look forward to being able to ask some questions of your successor, Chip Kahn, when he comes before our committee.

Mr. GRADISON. He sent me today.

Mr. GANSKE. Anyway, best of wishes in your, I'm sure, nonretirement, but future endeavors.

Ms. Ignagni, basically to follow up on the line of questioning of Mr. Brown. You like the parts of the IG report that compliment Medicare managed care, but you disagree with the parts of the GAO report, for instance, that basically show that an enrollee in Medicare risk plans costs about 65 cents in comparison to an average fee-for-service Medicare enrollee, but a $1.65, roughly speaking, for a risk plan disenrollee.

How do you justify picking out parts of that IG report that you like, but disregarding, in terms of our payment, the parts that are not so complimentary?

Ms. IGNAGNI. I appreciate the question. I think it is a fair one, and let me try to answer that as completely as I can.

First of all, it's curious that an IG report that is aimed at fraud and abuse in the traditional Medicare program then is used to make sweeping conclusions with respect to what is going on in Medicare risk right now and likely to go on in Medicare+Choice.

I think what I was trying to say, Dr. Ganske—whether I did it effectively or not, you will have to be the judge—but I think the issue is more complicated. I was also trying to say, in fact, that the IG has indicated that there are some unique characteristics here

that I think in managed care that we are losing sight of that can actually add to the situation.

As far as the risk profile, with all due respect, it has changed. I think that what you are hearing here from my colleagues, whether it's Ms. Riley, Mr. Sacco and others who can speak to it, it is no longer the case that we are treating people who are well, not sick; rich, not poor. We have been getting calls every day in our office from beneficiaries who are concerned about this.

Mr. GANSKE. Ms. Ignagni, when was that GAO report done?

Ms. IGNAGNI. Pardon?

Mr. GANSKE. When was that GAO report done?

Ms. IGNAGNI. This is the Inspector General report I was reading from.

Mr. GANSKE. I am speaking about the GAO report that shows that——

Ms. IGNAGNI. That was last summer, I believe.

Mr. GANSKE. Okay. So what you're suggesting is that there's been a sea change in what, 12 months?

Ms. IGNAGNI. Oh, no, sir. I am objecting to the GAO's conclusions. We do not agree with the GAO's conclusions in the report.

Mr. GANSKE. So you like some of the conclusions that were complimentary to your industry in the IG report, but you don't like the conclusions in the GAO report.

Ms. IGNAGNI. I didn't bring the IG report into the discussion. I was reacting to it. Mr. Brown raised the IG report. I was responding merely that it is a more complicated situation than I think we were talking about in the Q and A.

Mr. GANSKE. All right. Well, let me go on. As Deputy Administrator Hash noted, many of the plans who asked to have their ACR's refiled were able to make a similar timely filing for the Federal Employees Health Benefit Plan. So you are all sophisticated enough to predict rising costs of drugs and other inputs.

You noted that it was necessary to refile ACR's because they were submitted before Medicare's new regulations were issued and the higher costs imposed by them necessitated this move. Well, I am concerned that that's just a pretense for asking to refile.

Let me ask you this. Can your plans guarantee to HCFA that if they allowed ACR's to be refiled, that the plans would only make changes that reflected actuarially documented costs associated with HCFA's new regulations?

Ms. IGNAGNI. That's the argument that we made.

Mr. GANSKE. Okay.

Ms. IGNAGNI. Would you support us? I would hope that you might.

Mr. GANSKE. So that if we move toward this, it would only be in regard to the new regulations.

Ms. IGNAGNI. Actually, there were several points that we made. One is with respect to the new regulations. The second point was with respect to the unanticipated increase in health care costs that became very clear in the——

Mr. GANSKE. No, no, no, because the premise was you are sophisticated enough to make estimates of health care cost increases for FEHBP plans or otherwise. I am asking whether you would sup-

port ACR changes that would be allowed only for programmatic changes?

Ms. IGNAGNI. No, because I think there is reason to think about something else. And if you would allow me to answer the question, I would be delighted to tell you why. I think that, as you know, we are not in the habit of going to HCFA and making extraordinary requests irresponsibly.

We believe that there was a compelling reason for HCFA to take a look at this and endeavored to explain why. We also believed that it was, as Mr. Hash stated very well, and I think members of the committee, that we are being asked to do, as HCFA is and as the Congress is being asked to evaluate now, an extraordinary number of things in a very, very short period of time. That captures what's going on here.

Mr. GANSKE. But Ms. Ignagni, you also acknowledged to Congressman Brown that you basically disagreed with a whole series of government reports that he mentioned, as well. I only have time for one more question, I'm sure.

Mr. Bradley, I want to thank you for helping GM implement the Consumer Bill of Rights. My question is this. I recently had a conversation with John Forsyth, the president and CEO of Iowa Blue Cross Blue Shield for Iowa, Wellmark. So Mr. Sacco and Ms. Lehnhard, I would like your comment on this.

I was talking to Mr. Forsyth with a reporter from USA Today present. And Mr. Forsyth said that Wellmark is implementing a Patient Bill of Rights at minimal cost, almost nothing consequential, almost an exact quote from Mr. Forsyth.

Furthermore, Mr. Forsyth said, on that issue of liability—this is the president of Iowa Blue Cross Blue Shield—he said on that issue of liability, you know, if you have a plan like the Patient's Bill of Rights, not the HMO Protection Act, but the Patient's Bill of Rights, where you go up a review tree to an independent peer panel and that decision is then binding on the plan, then I would say the plan, if it accepts binding arbitration or binding peer review, should not be liable past that point.

But if a plan goes to the other part of the tree—in other words, chooses not to accept a binding arbitration or peer review panel recommendation—then it's only right that they would be like any other insurance company and accept the liability for their decision-making, because they are making medical decisions.

Would you care to comment on that comment from one of your fellow Blue Cross Blue Shield CEO's?

Mr. SACCO Well, I'm not sure that I would necessarily disagree with John in his entirety and in his response. First, let me say that in Oregon we have passed the most comprehensive patient protection program that exists anyplace in the country, and we are living with it.

In part, we have never said that we disagree with the concepts and the principles that have been enunciated at many of the State levels and at the national level here. Some of the issues have to do with how extensive the details are, mandatory versus voluntary.

With respect to your comment about health plan liability, we believe that there needs to be, and we believe that there are today and would be willing to expand adequate options and avenues for

patients to have decisions reassessed. That is not to say, however, that we support health plan liability. We think that opens up the economics of health plan reserves to untold litigation.

Mr. GANSKE. You have been implementing in Oregon, I take it, elements of a Patients' Bill of Rights, have you found that the costs have been excessive?

Mr. SACCO We have not yet had any significant noticeable impact. We don't have health plan liability. We do not have external review as a requirement within the Oregon statute. We do have broadened appeal rights within the structure created by each of the health plans.

As a health plan, we are examining the impact of external review. Certainly, external review on a voluntary basis sure beats mandatory health plan liability. I would not disagree.

Mr. GANSKE. And Ms. Lehnhard, your national organization has been vehemently opposed to the Patients' Bill of Rights, and has, along with AAHP, put out tons of literature about how expensive. And yet, you have testimony now from my report, from one of your CEO's in Iowa and from Mr. Sacco, that at least without considering the liability issue, that the cost to the plans of implementing the provisions of the Patient Bill of Rights are really minimal.

Mr. BILIRAKIS. A brief response to that, please, Ms. Lehnhard. Time has expired.

Ms. LEHNHARD. I want to clarify that I believe we are both speaking to the recommendations of the President's Commission, not any legislation.

Mr. GANSKE. Mr. Forsyth was speaking to the provisions of the legislation, the Patients' Bill of Rights.

Ms. LEHNHARD. And I think, with respect to the President's recommendations, our plans in principle agreed with it. It's when you start looking at the details. For example, requiring PPO's to comply with the same kind of rules that you have with HMO's. Those are very expensive initiatives.

Mr. GANSKE. But at least the anecdotal——

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. GANSKE. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Dingell.

Mr. DINGELL. Thank you, Mr. Chairman. That has been very helpful to us on the President's Commission on Medicare. Mr. Bradley, I appreciated your testimony on what GM does to ensure its employees and retirees receive high quality health care. It's apparent that GM and other employers in the auto industry and elsewhere have made the same commitment to quality that the Congress made in the Balanced Budget Act.

Currently, HCFA is in the process of developing Medicare's Quality Improvement System for Managed Care. Three questions: One, do you support the direction that HCFA is going with regard to quality?

Mr. BRADLEY. Yes, I do, because they are working, I think, very diligently with the private sector to try to have a common approach. Yet I do recognize that there are some issues with respect to it being a government agency that makes some of that difficult. But yes, directionally, I am very supportive.

Mr. DINGELL. You got the second question that I was going to ask. You are telling us then that their efforts are consistent with those of the private sector?

Mr. BRADLEY. I would say that most of them are.

Mr. DINGELL. Now, has HCFA been working with organizations such as yours in the private sector to converge measures and reduce administrative redundancy?

Mr. BRADLEY. HCFA participates on the Competitive Pricing—I'm sorry, yes, on that, of course—on the NCQA Committee on Performance Measurement, which has actually just undertaken a task to try to improve the efficiency of HEDIS measures, and that's in concert with the health plan.

We require NCQA accreditation, as you know. HCFA has to take perhaps a more broad-based view of that, but I think their expectations seem to be very consistent with that. The sheet which was passed out today, which albeit the first time I have seen it, I think does a nice job of outlining that.

There probably are some issues in the details and I am encouraged, just in my conversations with HCFA, of a genuine interest in trying to solve the problem or the burden and be as common as we can be.

Mr. DINGELL. I want to review that document, but I may have some further questions. Would you want to submit to us in writing, not at this time, any particular suggestions you might have with regard to how HCFA and organizations like yours and others in the industry working on this goal could better work together.

Mr. BRADLEY. Sure, I would be glad to.

Mr. DINGELL. All right. Now, Mr. Bradley, you also work with health care plans toward quality improvement. How is that to best be done? What are the requirements that we have to have before we can be assured that those kind of efforts are going to be successful?

Mr. BRADLEY. I think we are already seeing some evidence just by face-to-face discussions and meetings with health plans and specific examples in such things as improvement in care for people with diabetes. A particular program I just looked at where in their case management program, they virtually eliminated emergency room visits for diabetics out of control, and had substantial reduction in hospital days as a result.

There are many projects with asthma and others that are like that. The difficulty is—and I think we have to remember, we can't look at this as a regulatory or in a statistical way only, we've really got to spend time working with the health plans. And it is one of the unfortunate things about this whole HMO bashing, is that there are some really, really superior health plans doing wonderful things in these areas. But the way you know it is is you have to——

Mr. DINGELL. That's true, and there are some that are not.

Mr. BRADLEY. Right. And you have to have the face time with the health plans, know the medical directors, know their passion for quality improvement and separate those out from those that don't have that drive.

I wish there were some nice, simple way to measure it.

Mr. DINGELL. You do try to rate them, do you not?

Mr. BRADLEY. Oh, yes. And we use as many tools as we can.

Mr. DINGELL. And you believe that a rating system is not only possible, but desirable then, isn't that right?

Mr. BRADLEY. A rating system is desirable if it's linked in with multiple other approaches as well, and again, face-to-face visits. You know, we hired a team from the Permanente company, a subsidiary of Kaiser, to work with us to help health plans with improvement and identify areas, and that's what really is very, very effective, I think. There are some great health plans out there.

Mr. DINGELL. You had observed that the plan has to have both commitment and cooperation, isn't that right?

Mr. BRADLEY. Yes.

Mr. DINGELL. Now, last November, the President's Quality Commission issued its recommendations relating to patients' rights and responsibilities. Those recommendations almost in toto came to be embodied in the Patient's Bill of Rights.

In an executive order, the President has directed relevant Federal agencies to comply with these recommendations, many of which are already being done in the Medicare program. What do you think about the Consumer Bill of Rights and Responsibilities and requiring, to the extent the statute permits, plans to comply therewith?

Mr. BRADLEY. There are lots of versions and discussions about the bill of rights. And the one I am referring to is the appendix to the report of the Advisory Commission to the President, so we don't get mixed up.

Mr. DINGELL. We used that as the basis for drafting the legislation.

Mr. BRADLEY. Right. If you read the words very carefully in the bill of rights, in the recommendation to the Advisory Committee, we are very, very supportive of that and we are working with our health plans to move toward compliance with it.

There are some administrative issues and so on, but again, the direction is, I think, right, and there is nothing in it that I object to. I have a real concern about legislating it just because it becomes the devil is in the details and the interpretation and there can be some burdensome things.

We would like to have the flexibility to do this well and thoughtfully.

Mr. DINGELL. We do not quarrel on that, and I want to do that. When I hear about folks coming in and telling me how they want to do these things voluntarily, I am always wondering how well it would work if we were to have a voluntary law against robbing banks, or pushing old ladies down the stairs.

My experience with those things is that they don't tend to work very well.

Mr. BILIRAKIS. Would the gentleman finish up, please.

Mr. DINGELL. Well, if my time is done, I am willing to, but I was enjoying this greatly, Mr. Chairman.

Mr. BILIRAKIS. I know you were. That's why I wanted you to finish up.

Mr. DINGELL. Thank you, Mr. Chairman. If the witness, Mr. Bradley, could conclude, I will certainly conclude.

Mr. BILIRAKIS. Will you conclude very briefly, Mr. Bradley?

Mr. BRADLEY. Yes. I just wanted to say it is not as voluntary as you might think. We build accountability into all the work that we are doing with our health plans and this is part of that. The good news is that the health plans, I think, very much support these efforts.

Mr. BILIRAKIS. Thank you, Mr. Bradley.

Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman.

I guess I wanted to start out with a general statement about the fact that many of us, certainly myself, were not very pleased during this whole balanced budget debate about the fact that cuts were, in effect, taking place in Medicare that many of us felt were going to make the level of funding not adequate.

And at the same time, many of us, particularly Democrats, wanted to see expansion of Medicare to cover more services, prescription drugs or whatever it happened to be. And basically, I think we were kind of sold a bill of goods that said, okay, you don't have to spend more money, we can actually cut back on Medicare, but we can provide additional services beyond the basic Medicare package through HMO's.

I never believed that. I still don't believe it. And a lot of what you are telling me today convinces me that I was right. I feel very strongly that what is happening is that you are asking for more money, and the reason you are asking for more money is in part because you have to cover additional services that are not part of the basic benefit package.

Of course, there is also the other aspect, which is the for profit aspect of high salaries for executives and all that, too, and I think that is a factor. But I think there is a basic factor that in providing more services, it costs more.

So I guess I have two questions. One is why in the world should we provide additional money? If that's the case, why not just expand the basic benefit package? Let's include prescription drugs, and let's provide additional money so that we have that as a basic benefit.

Why bother with giving more money under a system that encourages HMO's, or where you may or may not have the benefit, depending on what HMO you choose or whether you have fee-for-service? That's my first question.

My second question is where do you expect this money to come from? Are you asking that the pot be restructured with the same level, or are you expecting us to provide more money? Because certainly under the Balanced Budget Act, there is no way to provide more money that I know of.

Two questions. We can start with Ms. Ignagni, since you seem anxious to answer.

Ms. IGNAGNI. Mr. Pallone, several responses. First, in our request to HCFA, what we were asking for was an opportunity for plans that felt that they needed to rebid to be given a short window to do that. We also shared with HCFA that the difference between a plan staying in an area or leaving in one particular case—and I can talk about a number of cases—but in one particular case, was increasing copays on prescription drugs by $1 to $2.

This gives you a very, very strong sense, I hope, of the type of modest changes we were asking for to address and to deal with the unexpected increase in prescription drug prices, particularly on the generic side. It's been going up more than 15 percent. That was not clear until midyear.

Mr. PALLONE. But can I just ask you one thing. Just tell me, isn't it a fact that one of the major reasons why you need more money is because you are providing benefits beyond the basic benefit package that Medicare provides? Isn't that a factor?

Ms. IGNAGNI. One of the reasons we were asking to have the opportunity in this transition year where everything was changing, was because what providers were telling many of our plans around the country is that it was not in their economic interest to continue to participate in Medicare+Choice.

Mr. PALLONE. Just answer me, because I am not asking what I think is a tough question. But isn't it a fact that part of the reason why you need more money is because you are providing a lot of benefits that go beyond the basic Medicare package?

Ms. IGNAGNI. The addition of——

Mr. PALLONE. Yes or no.

Ms. IGNAGNI. No, it's far more complicated than that. If you are not paying trend, then you are not able to provide contracts or contract with the providers that people expect to be in networks. Ms. Riley has used that as an example for why she is pulling out. You see that all around the country.

That's why I made the point about balance. You have to look at you are running two separate programs.

Mr. PALLONE. But looking at it from my perspective though, my perspective is you need more money, you say you are going to provide benefits that maybe fee-for-service doesn't provide. Why should we provide more money? Why not just expand the basic benefit package to include more services and then there is a justification perhaps for having more money?

Ms. IGNAGNI. I don't believe that anyone on our side in our constituency has ever engaged in any discussion in opposition to the idea that Congress would look at the basic Medicare benefit package.

We are here to talk about whether or not what has been done is adequate, whether it's workable, and what we can do in the future to sustain this as a choice. What we are doing now is we are telling beneficiaries that they are no longer going to be able to have access to catastrophic coverage, caps on copays, and the additional benefits.

So we are talking about dramatic cutbacks, with all due respect, far more of a cutback for beneficiaries than the modest increases would have involved. That's why we made the case.

Mr. PALLONE. I don't know, Mr. Chairman, it's up to you if you want to hear from others.

Mr. BILIRAKIS. Ms. Riley, very briefly.

Ms. RILEY. Just a friendly amendment to Ms. Ignagni's remarks, and that is that there are many markets in this country who are not offering additional benefits at all. The member is charged a monthly premium in my market, an average of $65 per member per month, just to cover Medicare part A, part B, their coinsurance

and their deductibles. No eyeglasses, no prescription drugs, no dental. That's just for the basic benefit package, and there are many, many markets like mine.

Mr. PALLONE. Mr. Chairman, if I could just say briefly to try to make my point, I just think that we'd be better off if we, instead of experimenting with what we're doing here with the HMO's, if we just simply said, look, we can probably provide more benefits, use prescription drugs as an example, probably get cheaper rates if we have it as part of a basic benefit package and we essentially force, if you will, a lower price.

I think that would achieve more than the sort of piecemeal approach that exists now where you are trying to compete and some of you offer some things and some of you offer others. That's just my own opinion, just so you understand where I'm coming from.

Mr. BILIRAKIS. Ms. Riley, are you saying that some of your plans are not providing additional benefits, but still they are getting out of the Medicare picture?

Ms. RILEY. That's correct.

Mr. BILIRAKIS. That's what you are saying. Thank you.

Mr. PALLONE. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you. This panel is excused with an awful lot of gratitude on our part. Thank you for your patience and for your willingness to help.

The third and last panel will consist of, Dr. Gail Wilensky, Chair of the Medicare Payment Advisory Commission, and Ms. Judy Feder, Professor of Public Policy, Georgetown University.

The latest is that we would have at least one vote in approximately a half hour, but it has been changing so I don't know how that is going to work out. Hopefully, we can finish up by then.

Dr. Wilensky, your written statement is a part of the record, as you know. You are very experienced at these things. I will turn the 5-minute timer on and let's see what we can do here.

STATEMENTS OF GAIL R. WILENSKY, CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION; AND JUDITH FEDER, PROFESSOR OF PUBLIC POLICY, GEORGETOWN UNIVERSITY

Ms. WILENSKY. Thank you. Good morning, Mr. Chairman and members of the subcommittee. I am here as Chair of the Medicare Payment Advisory Commission, and with me is the Executive Director, Murray Ross.

I just want to summarize a few issues that MedPAC has taken on both the HCFA regs and also on what we are hearing today about plan withdrawal, so we'll have plenty of time for questions.

The first thing is that this really is a timely hearing, because we are now 1 year out. Several things have happened that had not occurred earlier, so that you really couldn't have done this earlier. We now have several HCFA regulations, the one that was introduced at the end of June about Medicare+Choice, the so-called megareg; and also a risk adjustment regulation, proposed rule, that came out in September. And we have, as well, heard about a number of plans that are thinking about or who have actually withdrawn from Medicare risk, and therefore, this is a very timely period to be having this discussion.

MedPAC, as we are affectionately known, has made public and will make public in the future its comments to HCFA on regulations. We do that in a spirit of cooperation to try to share the members', the commissioners' views and the staff's views about what HCFA has put out.

And we think, in general, that the regulations that have come out have been good efforts and have a lot to support them. We think, for example, that HCFA's efforts to use Medicare's purchasing power to make sure that Medicare increases quality and the introduction of risk adjustment is appropriate and we support them.

We do have some cautions to make sure that when you are applying standards, that you don't do so in ways that will kill off innovation. We think that was clearly one of the things that Congress was trying to do in the Balanced Budget Act last year.

And we believe very strongly that the risk adjustment mechanism should be phased in. We have almost always, as MedPAC or the Physician Payment Review Commission, advised phase-ins when there is an significant kind of change. It allows for responses to occur and it mitigates in case there are some errors in terms of some of the estimates. As you know, you included that for the practice expense because of a lot of concern that some of the values there were inaccurate.

Let me make a comment about the plan withdrawal and the slow uptake in terms of new plans. To my mind, what we are seeing is clearly not what Congress envisioned. And while it is true, as Mr. Gradison said, that it appears only 5 percent of the people now in risk plans might lose their risk plans, as best we can tell, this was a time when we thought there would be substantial growth.

So the fact that we are seeing retrenchment and not growth is a surprise, and we think that we ought to acknowledge this was not what was expected.

MedPAC does not encourage you to reopen the Balanced Budget Act in a significant way for lots of reasons. But if you can find a way, or if HCFA can find a way to work with plans in ways that don't involve much money or maybe even any money to the program, either by looking at the issue with regard to the timing or some of the ACR requirements, that it is something that they should take with some real consideration.

And the reason isn't to help the financial health of the plans, but rather to understand what is going to happen to the seniors who have been or would have been included in new risk plans or in some other type of flexible plans.

Most of those people will find themselves back into the medigap market and at least as things now stand, that is a very expensive market to be in. So my concern and my plea, which I have done privately with HCFA, let me make this clear to you as well, that if there is a way to try to meet some of the concerns that were raised that does not just translate into give me lots more money, I think it is something that ought to be taken with seriousness.

Again, not because of the plans' sake, but because seniors will find themselves in a very expensive medigap market and that that is something which, if we can find a way to prevent, ought to be taken seriously.

Thank you. Let me now turn the rest of the time over to Dr. Feder.

[The prepared statement of Gail R. Wilensky follows:]

PREPARED STATEMENT OF GAIL R. WILENSKY, CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION

Good morning, Mr. Chairman. I am Gail Wilensky, Chair of the Medicare Payment Advisory Commission. With me today is Murray Ross, MedPAC's Executive Director.

In August one year ago, the Balanced Budget Act (BBA) of 1997 created Medicare+Choice, a new program intended to give Medicare beneficiaries new choices of private health plans, slow the growth in Medicare spending, and better target the program's resources. The new program takes effect January 1, 1999, although many provisions will not kick in until January 1, 2000.

Two reasons make this an opportune time to take stock of the new program. First, we now have information about how the Health Care Financing Administration (HCFA) proposes to implement Medicare+Choice. The agency issued an interim final rule on June 26th that laid out the ground rules for plans seeking to participate in the new program and published a notice on September 8th describing its proposed method of risk adjustment.[1]

The second reason concerns widely-publicized withdrawals of health plans from the Medicare market and the limited number of new types of plans that have indicated their intent to participate in the Medicare+Choice program. Policymakers are concerned that these events suggest the new program may not achieve its goal of expanding choices.

My testimony today describes the Medicare+Choice program, discusses the steps HCFA has taken in implementing it, and reports MedPAC's advice to the HCFA Administrator regarding the steps taken to date. I will also discuss the Commission's reaction to developments in the Medicare managed care market. Two main points flow from this discussion:

- MedPAC supports the agency's effort to harness Medicare's purchasing power to improve the quality of care for beneficiaries. We urge HCFA to apply standards to plans in a way that encourages innovation and variety in the delivery of health care. MedPAC supports the introduction of new risk adjustment methods to make payments to health plans correspond more closely to the expected cost of serving their enrollees. In view of the limitations in the interim method that has been proposed, however, MedPAC recommends that this method of risk adjustment be phased in, and urges HCFA to move to a method based on more comprehensive data as quickly as feasible.
- Recent plan withdrawals from the Medicare managed care program are clearly not what the Congress expected. The Commission cautions against reopening the BBA to make significant changes to the new program until the causes of these developments are better understood. At the same time, we recognize that plan withdrawals may have financial consequences for enrolled beneficiaries in some areas who may be pushed back into the Medigap market. Given the special circumstances during this transition year, HCFA should work with plans to find steps that could ameliorate the difficulties many plans face without raising program costs.

The Medicare+Choice Program

The Medicare+Choice program replaces the existing section 1876 risk contracting program and permits participation by a wide variety of private health plans. Under the new program, beneficiaries will be able to choose—in areas where they are offered—among a variety of coordinated care plans, including health maintenance organizations (HMOs) with or without a point-of-service option, preferred provider organizations (PPOs), and provider-sponsored organizations (PSOs). In addition, beneficiaries may enroll in private fee-for-service plans, and high-deductible plans offered in conjunction with a medical savings account (MSA).

The BBA modified the framework in which private health plans participate in Medicare, changing the responsibilities of both HCFA and participating plans. Notable among these changes is HCFA's new obligation to help beneficiaries make informed choices by routinely providing them comparative information about quality,

[1] See *Medicare Program: Establishment of the Medicare+Choice Program* (63 Fed. Reg. 34968) and *Medicare Program: Request for Public Comments on Implementation of Risk Adjustment for the Medicare+Choice Program and Announcement of Public Meeting* (63 Fed. Reg. 47506).

access, financial liability, satisfaction, and financial stability for all plans serving their area. Participating plans are required to report detailed information to enable HCFA to undertake this responsibility and to facilitate program quality assurance. The BBA also established the framework for the Medicare+Choice quality assurance program, which features requirements for quality improvement activities and external quality review that differ by plan type.

The BBA also made significant changes in the way health plans are paid, by severing the link between county-level trends in fee-for-service spending and payment updates to plans, instituting a floor under county payment rates, blending local and national payments rates, and removing the component of base rates attributable to spending for graduate medical education. Further, it directed the Secretary of Health and Human Services to implement risk adjustment by January 1, 2000.

Until 1998, Medicare's payments to private health plans in a county were based on the average payments made on behalf of beneficiaries in its traditional fee-for-service program in that county. Under the Medicare+Choice program, payment rates are no longer based solely on local fee-for-service spending. Instead, base payment rates for each county are calculated as the higher of:

- a blend of an area-specific (county) rate and a national rate;
- a minimum or floor rate; or
- a rate reflecting a minimum update of the county's rate from the previous year.

The blended rate is designed to shift payment gradually away from local county rates, which reflect wide variation in fee-for-service costs and use of services, toward a national average rate. Blending will generally reduce payment rates in counties where payment rates have historically been higher than the national average rate, and will increase rates in counties where payments have been lower. Other things being equal, this should stimulate plan participation and beneficiary enrollment in areas where payments rise and dampen enrollment growth—and perhaps plan participation as well—in areas where payments fall.

MedPAC's Comments on HCFA's Proposals for the Medicare+Choice Program

HCFA's interim final rule (the rule) establishing the Medicare+Choice program addresses a number of issues, including information for beneficiaries, quality assurance, and payments to participating plans. This section summarizes MedPAC's comments on these provisions where HCFA had discretion in implementing the BBA.[2]

Information for Beneficiaries. Medicare+Choice organizations will be required to provide certain information to their enrollees upon enrollment and annually thereafter. Routinely disclosed information must be provided in a clear, accurate, and standardized format and describe the plan's service area, benefits, number and mix of providers, coverage arrangements for out-of-area and emergency care, supplemental benefits and related premiums, prior authorization rules, procedures for filing grievances and appeals, disenrollment rights and procedures, and quality assurance program.

Recognizing that comparative information is critical both to empower beneficiaries and to support program oversight, MedPAC supports the information disclosure requirements established in the BBA and reiterated in the rule. However, as HCFA begins to develop specific reporting requirements, it should take care to weigh the informational value of each item against the costs borne by plans and providers in reporting it. Further, HCFA should carefully coordinate the information requirements it imposes on its plans with the encounter data standards it establishes to support risk adjustment of payments. To the extent possible, both disclosure requirements and encounter data needs should be met using common data elements with consistent definitions and measures.

Quality Assurance. As directed by the BBA, the rule requires participating plans to have an ongoing quality assessment and performance improvement program. All plans will be required to maintain information systems to collect, integrate, and analyze the data needed to assess and improve quality. They will also have to ensure the reliability and completeness of data collected from providers. Coordinated care plans—but not MSA plans or private fee-for-service plans—will be obliged to achieve minimum performance standards established by HCFA. Coordinated care plans and network MSA plans must also conduct projects to demonstrate sustained improvement in significant clinical and nonclinical aspects of care.

Implementation of these quality standards will pose formidable challenges. Yet to be addressed are issues such as:

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[2] The complete text of MedPACs official comments are contained in a September 10th letter to the Administrator of HCFA. Copies of this letter, as well as a MedPAC staff summary of the rule, are available from the Commission.

- how to set standards without unduly restricting innovation and competition;
- whether quality measures can be identified that would permit meaningful comparisons across different types of plans and between those plans and traditional Medicare;
- how to adjust for important differences in enrolled populations when reporting performance measures; and
- how to reduce opportunities for manipulating the system at junctures such as choice of quality improvement project.

MedPAC is also concerned that the quality assurance system set forth in the rule will pose significant barriers to participation for all but the most tightly managed coordinated care plans. For example, plans with large, loosely organized networks may face challenges reporting certain types of quality measures or influencing practice behavior. MedPAC recognizes the value of establishing common standards where possible, but believes that different standards will be necessary in some instances to reflect differences in plans' organizational structures and roles in care management. The Commission suggests HCFA consider additional ways to create equivalent standards where uniform standards are not feasible.

Payments to Medicare+Choice Organizations. As with other topics addressed by the rule, the regulations concerning payment closely follow the BBA. In several areas, though, HCFA has used general program administration authority to define payment policies that are more prescriptive than was the case in the section 1876 risk contracting program.

Uniform Benefits and Plan Service Area Policy. Medicare's payment rates can vary considerably, even among counties within a single metropolitan area. Under the old risk program, plans could offer different benefit and premium combinations in different counties within their service areas to reflect differences in Medicare's payment rates. Current risk contractors will continue to be allowed to offer flexible benefits in 1999, as a transition to Medicare+Choice status. After that, however, plans must provide uniform benefits at a uniform price to all enrollees across their entire service areas.

One way plans could continue to offer coverage across areas with diverse payment levels would be to divide their service areas into smaller units and match their benefit packages to the payment rates. But the preamble to the rule suggests that after 1999, plans will meet resistance in the plan approval process if they do this. Further, the rule requires service areas to stand alone in terms of meeting network access requirements. If plans could not meet these requirements, Medicare+Choice organizations might decide not to serve these counties at all. The Commission is concerned that beneficiaries in low-payment counties may have decreased access to Medicare+Choice plans as a result.

The Commission thus recommends that the agency maintain flexibility in this process and seek a legislative change that will allow flexible benefit offerings across counties. In the absence of such a change, plans may have difficulty providing uniform benefits across multi-county service areas because of differences in payment rates, and might abandon lower paying counties in metropolitan areas. This would be to their advantage because they could offer richer benefit packages than could plans with wider service areas that continued to average in the lower payments from the other counties.

Adjusted Community Rate Proposal Calculation. The rule revises the adjusted community rate (ACR) proposal, essentially changing it from an actuarial estimate of costs to a report of actual costs incurred, with allowable adjustments. Administrative costs will be separated from additional revenues, which include profits, contribution to surplus, risk margins, and contributions to risk reserves.

MedPAC supports efforts to improve the ACR by making it better reflect actual costs. However, an ACR based on reported costs will probably require plans to provide more benefits and give them less financial slack to make up for unanticipated fluctuations in costs or payments, or errors and biases in accounting systems. HCFA should therefore monitor the impact of changes to the ACR and revisit policies regarding the benefit stabilization fund (a fund into which plans may contribute surplus payments to allow the provision of stable benefit packages over time).

In addition, the Commission advises examination of alternatives to the ACR for ensuring good value from private fee-for-service and MSA plans. Various aspects of the standard ACR approach do not work well for these plans, but it may be reasonable and desirable to have plans report the relevant ACR information, or to develop reporting standards that would ensure good value for beneficiaries. At a minimum, all plans should be able to report their Medicare costs.

Adjusted Community Rate Proposal Review and Audit. The BBA and the rule provide for increased federal government scrutiny of ACR proposals, with the former

requiring that data be audited, and the latter requiring that organizations certify data accuracy.

MedPAC urges the allocation of adequate funds and personnel for these functions. The Commission believes that beneficiaries should share in the efficiencies of managed care plans and is concerned that the ACR is the only way to enforce this requirement in areas with minimal competition. HCFA should develop reports on the value delivered by plans, and should focus audits and review of data and assumptions on areas where payments exceed costs in traditional Medicare and on plans—particularly those offered by provider-sponsored organizations—in markets with little competition. At the same time, MedPAC recognizes that Medicare+Choice organizations need time to adapt accounting systems to produce ACR proposals using the new methods. The Commission recommends HCFA take this into account in its review of ACR calculations and data.

Risk Adjustment. Risk adjustment is the process of setting capitation rates that reflect health status, paying plans more to care for ill beneficiaries than for healthy ones. Through 1999, monthly payments to private health plans under Medicare will continue to be based on the current risk adjustment method, under which payment to a plan for a particular enrollee is the product of the base payment amount for the county and the enrollee's risk score. Until this year, the base payment reflected 95 percent of the amount Medicare would expect to spend on behalf of an average beneficiary in the traditional fee-for-service program in that county. (For 1998, the base payment rate was set using the rules laid out in the BBA.) The risk score, which is assigned on the basis of an enrollee's age, sex, eligibility for Medicaid, and whether or not the enrollee is institutionalized, reflects expected spending for that enrollee compared with spending for the average Medicare beneficiary in the traditional fee-for-service program.

Medicare's existing method of risk adjustment is widely acknowledged to be inadequate because its components account for very little of the variation in beneficiaries' health and use of health care services. As a result, program spending has been higher than it would have been had payments more closely matched the cost of caring for the relatively healthier people who enrolled in managed care. Inadequate risk adjustment leads to health plans having gains and losses unrelated to their efficiency in delivering care, and may also affect access to care for beneficiaries with high-cost health conditions. In 1997, both the Physician Payment Review Commission and the Prospective Payment Assessment Commission recommended that Medicare adopt risk-adjusted capitation rates based on health status to mitigate these problems.

The BBA provided a specific mandate and timetable for improving risk adjustment in the Medicare program, directing the Secretary to develop and implement a new risk adjustment methodology by January 1, 2000. This deadline in turn requires the Secretary to announce the risk and other factors that will be used to adjust county-level payment rates by March 15, 1999. However, as a practical matter, HCFA will have to establish its methodology much sooner.

In its September notice, HCFA proposed to implement a risk adjustment system based on enrollees' demographic characteristics and expected relative health status. Initially, health status would be measured using principal inpatient diagnostic cost groups (PIP-DCGs), and principal diagnoses associated with any hospital stays that occurred during the preceding year. That is, the risk score for an enrollee is intended to reflect the enrollee's higher expected costs in the year following a hospitalization. Information about prior hospital stays would be obtained from encounter data submitted by plans for current enrollees and from fee-for-service claims for new enrollees. Some time after 2002, the agency would incorporate information from encounter data from additional sites of care for the purposes of risk adjustment.

Effect of Risk Adjustment on Payments. The new risk adjustment method will change payments to health plans both individually and in the aggregate. Payments to individual plans are likely to change because the new system will be much more sensitive to differences in health status among beneficiaries, so that the average risk score for plans' enrollees may vary substantially. In addition, aggregate payments to plans are likely to decline because the relative healthiness of enrollees—which has not been captured by the current risk adjustment system—will be captured, to some extent, under the new system.

Issues. HCFA's proposed risk adjustment system raises both near- and longer-term issues. In the near term, key questions include:

- What should be done if the encounter data now being collected are inadequate?
- How should payments for new Medicare beneficiaries—for whom no encounter data or fee-for-service claims will be available—be set?
- Should the new method be phased in to avoid wide swings in payments?

- Should an outlier policy be adopted to protect plans that enroll a large percentage of beneficiaries with unexpectedly high costs?

Over the longer term, key questions include:

- How can the model be expanded to account for predictable costs other than those attributable to an inpatient hospital stay?
- Should a multi-year risk adjustment model be adopted to account for predictably higher spending beyond the first year following a hospital stay?

MedPAC's Comments. In our March 1998 *Report to the Congress: Medicare Payment Policy,* MedPAC made a number of recommendations with regard to risk adjustment. One key recommendation was that Medicare should move as quickly as feasible to develop the capability to use diagnosis data from all sites of care for risk adjustment. We continue to be concerned with the incentives inherent in a risk adjustment system in which health status is measured solely by hospital inpatient diagnoses. Inpatient data are easier to collect, but relying solely on them distorts incentives regarding hospitalization. It encourages plans to favor inpatient over outpatient modes of treatment, and it penalizes plans that are good at substituting ambulatory care for hospital stays.

In the interim final rule issued in June, HCFA noted that it will provide advance notice to Medicare+Choice organizations to collect and submit data on the use of physician, hospital outpatient, skilled nursing facility, and home health agency services, and that the submission of such data will be required no earlier than October 1, 1999. This timetable will permit implementation of a risk-adjustment system that uses this non-hospital data no earlier than 2003.

MedPAC is concerned about leaving an interim system in place for three or more years and believes there should be a substantial effort to move Medicare+Choice payments quickly beyond such a system.

A second recommendation in our March report was that, as soon as feasible, HCFA should refine its risk adjustment methodologies to allow for the persistence of higher expected costs beyond the first year following diagnosis of a serious condition. Under the single-year method, the rate paid for an enrollee will fluctuate inappropriately over time for many enrollees. We recognize, however, that developing and testing such a refinement is a complicated task that might not be completed for four or five years.

Finally, MedPAC recommended that Medicare undertake a large-scale demonstration of partial capitation or other methods that would pay plans partly on the basis of a capitated rate and partly on the basis of payment for services used. By itself, risk adjustment may reduce incentives for risk selection, but it will not create neutral financial incentives for plans to provide specific services. Risk sharing in the form of partial capitation may be more economically neutral than either fee-for-service payment or capitation alone.

In addition to these recommendations, MedPAC is currently reviewing HCFA's September notice and will make comments available early next week. Those comments will expand our advice to HCFA regarding phase-in methods that could be adopted to temper the effect of risk adjustment on payment rates. One approach might be to establish corridors around the annual change in each plan's payments per enrollee. Alternatively, a phase-in might be accomplished by blending the payment amounts that would apply under the current system with those that would apply under the interim system. However, both of these phase-in methods would permit plans to continue receiving higher payments than the best available risk measure suggests they should receive.

Next Moves

While the Medicare+Choice provisions of the BBA greatly expanded the array of plans eligible to participate in Medicare, only three non-HMO plans had sought to do so as of late August. And over the past few months, a number of plans have announced their intention to withdraw from or scale back their operations in particular Medicare markets. While some of these withdrawals are related to developments in the broader health insurance market, many plans have cited low Medicare payment rates and concerns about the costs of meeting the standards of the Medicare+Choice program as the reason for their actions.

These developments have raised questions in the minds of policymakers about whether the promise of the Medicare+Choice program will be realized and whether action is needed to boost payment rates to avoid future withdrawals, to modify certain regulatory requirements, or to mitigate the effects of risk adjustment. While these are clearly important questions, we are not yet in a position to give definitive answers to them. Two general considerations are relevant, however.

First, we note that in passing the BBA, Congress intended to slow the growth in payments to private plans and to make payments more equitable across counties—

through blending—and across plans—through risk adjustment. By their very nature, these policies will change payment rates in ways that lead plans to retrench in some areas and to take advantage of opportunities newly available to them in other areas. The passage of time will help us determine whether this is taking place. Sudden changes in local markets are clearly a concern, however, and enrollment and plan participation should be closely monitored to guard against disruptions in beneficiaries' health care.

Second, circumstances during this transition year are unique. When the implementing regulation came out in June, existing plans had already filed their ACR proposals and could not account for any new costs imposed by the rule. New plans had little time to make decisions about whether to participate in 1999. Combined with continuing uncertainty about the impact of risk adjustment, it is likely that many plans adopted a wait and see attitude. Next year should provide better evidence of whether plans will participate in the program and how beneficiaries will react to their new choices.

While the lack of good information makes it premature to reopen the BBA, these considerations suggest recognizing this year's special circumstances. HCFA should work with plans to see if changes in regulation—such as postponing implementation dates, reviewing aspects of the quality assurance program to find better or less costly ways to collect data, or allowing plans to revise their ACRs—could ease the difficulties faced by plans and preserve beneficiaries' access while not raising program costs.

This concludes my prepared statement. I am happy to answer your questions.

Mr. BILIRAKIS. Thank you. Professor Feder. I apologize for messing up the name. I get that all the time, so once in a while I want to dish it out.

STATEMENT OF JUDITH FEDER

Ms. FEDER. It's perfectly all right. I'm sympathetic.

I am glad to be here before you this afternoon, and I would appreciate your making my full statement a part of the record. What I would like to do briefly to actually close your discussion is to put the issue that we've been discussing this morning, indeed, the Medicare+Choice program, in the broader context, both of the Balanced Budget Act of 1997 and of the Medicare program.

By establishing the Medicare+Choice program, BBA did indeed chart a new course for the program, moving it beyond its traditional role of paying bills for medical services into the role of managing a marketplace of private health plans.

Your intent here, I believe, was not and should not become, the preservation or enhancement of managed care plans' revenues or profit levels. Rather, it was and should remain a part of your efforts to slow overall cost growth in the Medicare program and to promote efficiently provided, high-quality care for Medicare beneficiaries.

Limiting demonstrably excessive payments to managed care plans was an explicit objective of BBA, alongside slowing growth in the fee-for-service system. Equally important was your commitment to enabling HCFA to act as a prudent purchaser by holding private health plans accountable for the delivery of quality care.

With respect to both cost containment and accountability, the BBA's intent and HCFA's implementation closely parallel the behavior of other purchasers, private employers, in pursuing similar arrangements, as we've heard this afternoon.

Claims from the industry that Medicare payments are too low, or requirements are too high, should not derail HCFA or the Congress from these fundamental obligations to protect both taxpayers and beneficiaries in managing the Medicare program.

Let me elaborate briefly on each of the points. First, I want to highlight for you both the goals and accomplishments of BBA 97. Perhaps the most important objective you were pursuing there—and we haven't talked much about it today—was to slow growth in Medicare expenditures, and you were an enormous success, extending the life of the trust fund from 2001 to 2008 and bringing Medicare spending growth in line with projections for the private sector.

Limiting growth in payments to managed care plans was a part of the BBA objective, especially in light of what we have spent a great deal of time on today, the overpayments that go to managed care plans in Medicare.

As has been emphasized, although the intent of the previous rules, the rules in Medicare, had been to pay managed care plans 5 percent less than beneficiaries enrolled would cost in the fee-for-service system, the facts are that we are spending at least 5 percent more than it would cost in the system. And BBA has intended, and you are proceeding, HCFA is proceeding, to address this problem, better relating payments to enrollees' costs.

It was at the same time that BBA sought to enhance the fairness of payments and to promote the availability of managed care plans more broadly across the country.

What I think we have to recognize is that to some extent these objectives are offsetting, that measures to slow Medicare cost growth overall and to reduce these overpayments through limits and risk adjustments, tend to offset what you are trying to do to enhance the payments in areas where plans don't exist.

But on balance, the relatively high historical payments to managed care plans provide them with a strong cushion to absorb lower rates of increase in the future—they have a healthy base here—and still earn healthy returns and provide broad benefits to Medicare enrollees, consistent with quality standards like those that are being applied in the private sector.

Expectations that managed care plans can continue to operate successfully at these levels are further justified by plans' claims about the substantial efficiencies they can achieve in managing and coordinating care.

The second issue, and equally important in the BBA, are HCFA's responsibilities and performance as a prudent purchaser. Advocates of a choice system emphasize the importance of management of that system, whether by government or private employers, in making a market work.

The key purchaser roles include the establishment of quality standards, protection against fraud and abuse—particularly important where taxpayer dollars are at stake—assurance of patient protections, and risk adjustments and consumer information and education.

HCFA, consistent with the BBA, has been proceeding admirably in all areas under the constraints of quite limited resources and staffing. I think that has been a particular concern in the area of consumer education, but it is an area overall.

To conclude, Mr. Chairman, on getting to the issue of the complaints that the plans have made, not only do prior payment levels and the appropriateness of Medicare's requirements raise questions about the industry's claims, the claims are also suspect when con-

sidered alongside the industry's resistance to particular Medicare requirements, the provision of encounter data, to develop the very important risk adjustment system.

They are further questionable given what we have seen in the private sector in terms of plans' responses to quality assurance. The National Committee on Quality Assurance reported last week that nearly half the plans that publicly reported their performance on quality measures last year, refused to do this year. And it was reported this week that for three of the five measures used by Medicare for its managed care plans, a significant number of plans were unable to produce reliable data, according to audits.

The fact that only around 75 percent of plans were able to produce reliable data on the numbers of their diabetic enrollees who got eye exams, raises serious questions about plans' abilities to deliver the care management that Medicare is ostensibly purchasing and that beneficiaries count on.

Mr. BILIRAKIS. Professor, I am not belittling the significance of what you are telling us, but please summarize.

Ms. FEDER. Absolutely. In closing, what I want to say is I'd like to remind you that we are a year past the enactment of this law, but we have only begun to implement it. To act precipitously at such a time would likely be a mistake.

Second, as you monitor the implementation of the law, it is your job to keep in mind the fundamental objectives, not only behind this initiative, but for the program as a whole. And that is providing Medicare beneficiaries access to high-quality care, while protecting taxpayers, as well as beneficiaries, by controlling program costs.

I would suggest in that regard that you ought to stay the course. The law is being implemented with respect to Congress' intent, or consistent with, and my advice is not to abandon the course you have set out on. Thank you.

[The prepared statement of Judith Feder follows:]

PREPARED STATEMENT OF JUDITH FEDER, PROFESSOR, GRADUATE INSTITUTE OF PUBLIC POLICY, GEORGETOWN UNIVERSITY

Mr. Chairman, members of the Committee, I welcome the opportunity to testify before you today on the Medicare+Choice program, one year after its enactment. As you undertake this evaluation, it is critical that you place the program in context.

By establishing the Medicare+Choice program, the Balanced Budget Act of 1997 charted a new course for the Medicare program—moving it beyond its traditional role of paying bills for medical services into the role of managing a marketplace of private health plans, which, in turn, are expected not simply to pay bills but to manage care. Your intent in moving Medicare in that direction was not—and should not become—the preservation or enhancement of managed care plans' revenues or profit levels. Rather, it was and should remain a part of your efforts to slow overall cost growth in the Medicare program and promote efficiently provided, high quality care with a broad array of choices for Medicare beneficiaries.

Limiting demonstrably excessive payments to managed care plans was an explicit objective of the Balanced Budget Act of 1997, alongside slowing growth in payments in the fee-for-service system. Equally important was the Act's commitment to enabling the Health Care Financing Administration (HCFA) to act as a "prudent purchaser" by holding private health plans accountable for the delivery of quality care. With respect to both cost containment and accountability, the BBA's intent and HCFA's implementation closely parallel the behavior of private employers in pursuing similar arrangements. Claims from the industry that Medicare payments are too low, or requirements too high, must not be allowed to derail HCFA or the Congress from these fundamental obligations to protecting both taxpayers and beneficiaries in managing the Medicare program.

The following presents these arguments in greater detail, addressing first, the objectives and accomplishments of the Balanced Budget Act of 1997; then, government's responsibilities and performance in establishing itself as a prudent purchaser; and finally, the implications of both for evaluating the current status of Medicare+Choice.

Goals and Accomplishments of the Balanced Budget Act of 1997 (BBA). Perhaps the most important objective and accomplishment of the BBA was to slow the growth in Medicare expenditures, consistent with efforts to balance the federal budget and to extend the life of the Medicare trust fund. The most recent report of the Medicare trustees shows that actions taken in the BBA extended the life of the trust fund from 2001 to 2008. These actions slowed Medicare's cost growth to below levels projected for private spending for the next five years and roughly on a par thereafter.

As noted above, limiting growth in payments to managed care plans was a part of BBA's objectives. Over a period of years, the Congressional Budget Office, the Physician Payment Review Commission and other analysts have demonstrated the overpayments to managed care plans resulting from both the payment formula and favorable selection into managed care plans. In other words, although Medicare's intent was to pay plans 5 percent less than the costs of similar beneficiaries in the fee-for-service system, in reality Medicare has been paying plans at least 5 percent more than their fee-for-service costs would have been—because the plan enrollees are healthier and less costly than the average beneficiary. The BBA addressed this problem, not only by limiting growth in payments to managed care plans, but also by requiring the implementation of a risk adjustment system starting in 2000 to better relate payments to enrollees' health status and likely costs.

At the same time, the Balanced Budget Act sought to enhance the fairness of payments and promote the availability of HMO services in areas without them by raising payments for plans in parts of the country with relatively low health costs (offset by moderating growth in payments in high cost regions) and by establishing a minimum payment in rural areas.

To some extent, these objectives are offsetting: measures to slow Medicare cost growth overall and to reduce overpayments through limits and risk adjustment tend to offset efforts to enhance payments to managed care plans in some communities. However, on balance, the relatively high historical payments to managed care plans provide them with a strong cushion to absorb lower rates of increase in the future and still earn healthy returns and provide broad benefits to Medicare enrollees, consistent with quality standards equivalent to those applied in the private sector. Expectations that managed care plans can continue to operate successfully at these levels are further justified by plans' claims that they can achieve substantial efficiencies by managing and coordinating care for their patients.

HCFA's Responsibilities and Performance as a Prudent Purchaser. Advocates of choice of and competition among health plans have always emphasized the importance of the purchaser—whether government or a private employer—in making a market work. Key purchaser roles include the establishment of quality standards; protection against fraud and abuse; assurance of patient protections; risk adjustments to prevent undesirable risk selection and overpayment; and consumer information to make choices in the marketplace.

Both the BBA and HCFA's implementation of the BBA gave considerable attention to these roles. The law requires, and HCFA, through regulations and guidance (provided through the Quality Improvement System for Managed Care or QISMC), has put forward a set of *quality standards* developed in collaboration with the health care plans and consistent with standards developed for the private sector through the National Committee for Quality Assurance (NCQA). Although efforts to promote quality are important throughout the Medicare program, they are particularly important in managed care plans because these plans can and do limit the range of providers available and services that enrollees can receive.

Fraud and abuse protections, aimed at assuring the appropriate use of public funds, are also in progress. Some have argued that a move away from fee-for-service and its claims-filing process dramatically reduces the potential for fraud and abuse. But managed care raises its own potential for fraud and abuse—most importantly receipt of funds in advance without delivery of services when needed. Ongoing attention to the appropriate use of taxpayer funds remains a critical oversight responsibility.

Consistent with the action many states have taken, both the BBA and HCFA regulations also require that all managed care plans provide a minimum set of *patient protections.* These protections aim essentially to assure beneficiaries that the plan they choose will deliver the services they are entitled to—and will give them recourse for complaint if problems arise.

HCFA has recently promulgated its methodology and established data requirements for developing a *risk adjustment* mechanism designed to better relate payments to enrollee costs. The proposed mechanism aims at one of the Achilles heels of any system of competing insurance plans—the tendency to segregate the healthy from the sick. As noted above, plans' tendency to enroll healthier than average beneficiaries has produced substantial overpayments by the program. Risk adjustment, which has already been implemented by a number of large private purchasing groups, is a critical step to assuring that plans are neither over nor underpaid.

Finally, providing consumers with accurate and useful *information* for making enrollment decisions is one of the biggest responsibilities and biggest challenges faced by Medicare and private payers alike. In both sectors, we have limited experience in effectively comparing plans on quality and other dimensions and in communicating those comparisons in ways consumers can readily understand. Medicare faces the additional challenge of scale—communicating directly with almost 40 million beneficiaries spread throughout the country.

HCFA has only begun to address the consumer education challenge and needs to go further in this direction. However, its ability to address the problem is significantly hampered by strained resources. Resources currently available to undertake this massive effort—which requires access to telephone hotlines and, many believe, counselors or ombudsmen as well as comprehensible written materials—amount to only $2.44 per beneficiary per year and allow only 7 minutes per estimated phone call. Advocates who know the time and attention it takes to assist elderly clients in navigating the traditional Medicare program regard current resources as grossly inadequate.

In all these areas, the steps that HCFA has taken are essential to achieving its role as a prudent purchaser—that is, to assure that managed care plans are managing care. HCFA is taking these actions in a timely fashion, despite little if any increase in staffing or resources. Further, HCFA's implementation of BBA's requirements is quite consistent with actions that private purchasers have taken. The goal for the future should be to build upon and strengthen these requirements, not abandon them.

Evaluating plans' complaints about Medicare+Choice. Today's hearing is largely stimulated by the managed care industry's claims that a crisis has arisen in the implementation of Medicare+Choice—specifically, that lower-than-anticipated payment levels and higher-than-anticipated requirements are threatening managed care plans' ability to profitably serve the Medicare market.

Not only do prior payment levels and the appropriateness of Medicare's requirements call these claims into question. They are also suspect when considered alongside the industry's resistance to particular Medicare requirements: the provision of the encounter data needed to establish a risk adjustment system to assure that payments reflect the health status of enrollees and do not over or under pay. No analyst disagrees with the importance of a risk adjustment system to making a market promote efficiency rather than risk selection. Industry's resistance to the system's implementation calls its commitment to efficiency into question.

Further reason to question the industry's commitment comes from its reaction to measures of quality performance. NCQA reported last week that nearly half the plans that publicly reported their performance on HEDIS measures last year refused to do so this year. And this week it was reported that for three of the five HEDIS measures used by Medicare for its managed care plans, a significant number of plans were unable to produce reliable data according to audits. The fact that only around 75 percent of plans were able to produce reliable data on the numbers of their diabetic enrollees who got eye exams raises serious questions about plans' ability to deliver the care management that Medicare is ostensibly purchasing and that beneficiaries are entitled to expect.

Plans argue that payments are inadequate to enable them to meet the requirements that Medicare is imposing. And, they are responding to payment constraints by threatening to raise premiums, reduce benefits, or leave the program. This response is peculiar in light of the continued growth of managed care in the private sector, in the face of many private purchasers' even more aggressive constraints on premiums. It is also highly disruptive to beneficiaries, who have a right to expect stability in the marketplace the BBA has put before them and who bear the real cost of any preciptious actions plans take. Given the historical generosity of payment levels to date, it is hard to accept plans' responses as justified on the grounds of truly inadequate resources. In Medicare, as in the private sector, we should expect health plans to respond to reasonable premium constraints by managing care.

The industry's inability or unwillingness to respond to reasonable private as well as public sector oversight cannot be used as a justification for raising Medicare payments. To do so in the absence of a guarantee that plans are providing the level

of care they promise would be an abdication of management responsibility. The goal, after all, is not to promote managed care plans; it is to assure management of appropriately provided, quality care.

Perspective on Medicare+Choice. As you examaine Medicare+Choice a year after the program's enactment, it is first of all important to remember that implementation of the program has only just begun and will take time. Second, as you monitor its implementation, members of Congress must keep in mind the fundamental objectives not only behind this initiative but for the Medicare program as a whole—that is, providing Medicare's elderly and disabled beneficiaries access to high quality care, while protecting taxpayers as well as beneficiaries by controlling program costs. Achieving that goal requires steadfast management—holding plans accountable to a reasonable set of standards and holding payments made throughout the system to reasonable levels. That is the course the Congress intended and the course HCFA is on. My advice is not to abandon it.

Mr. BILIRAKIS. Thank you. I will start off the questioning, if I may. Professor, you mentioned quality and certainly, that's why I said we can't belittle that particular point, but does HCFA have any data at all on the quality regarding the fee-for-service system?

Ms. FEDER. I think HCFA has engaged in efforts to promote quality and service adequacy in fee-for-service along with managed care.

Mr. BILIRAKIS. But is there any data regarding fee-for-service?

Ms. FEDER. There's no question that it is hard to get the data in the fee-for-service system. I would not deny that. The efforts that I am aware of is that they are attempting to hold themselves to standards on the delivery of mammograms——

Mr. BILIRAKIS. Why isn't there any data?

Mr. GANSKE. Mr. Chairman.

Mr. BILIRAKIS. I mean, they have a concern in that regard, do they not?

Ms. FEDER. Certainly, we have data on service use patterns. I was turning to mammograms as an example. So we can use claims data to hold the fee-for-service system accountable, as we are holding managed care plans accountable.

Mr. BILIRAKIS. The gentleman.

Mr. GANSKE. Mr. Chairman, as a former practitioner in Medicare, I can tell you that HCFA sends out voluminous reports and rules and regulations that deal with quality issues on practically every aspect of what you would do.

I mean, when I was in practice, I had volumes, not all of which related to things that I did, but over all the medical spectrum. The main thrust of most of them were to ensure quality and also to prevent abuse or fraud in the system.

It's almost weekly that you will get a packet.

Ms. FEDER. We have also had for many years peer review organizations that are examining patterns of care in communities throughout the Nation.

Mr. BILIRAKIS. Do you have anything to add to that, Dr. Wilensky? I thought you might.

Ms. WILENSKY. Yes, thank you, as somebody who was involved with this issue. HCFA has not been able to impose the same kinds of quality standards in the past in the fee-for-service world, including traditional Medicare, because the systems that are present in a managed care system are not present in fee-for-service.

There has been an attempt, an admirable attempt, on a demonstration basis, to try a couple of areas, particularly with regard

to diabetes care, to see whether or not they could put in some requirements for feedback of information about whether or not certain preventive care activities that were taken occurred in some limited number of practices.

But, in fact, if you speak to the people at HCFA, what they will tell you is their ability to get information on quality and outcomes is very limited in the ala carte fee-for-service world, compared to the requirements that they have imposed on a system. And it is an advantage.

There are other issues that have been raised from time to time about potential disadvantages, but this is one in which HCFA has consistently said their ability to produce information, to require information, is much more limited. And in fact, one of the questions that is coming out right now is whether the requirements for quality that have been imposed on the more loosely organized groups like PPO's or private fee-for-service plans, whether or not they will be able to provide the information that HMO's traditionally have because of the different nature of their organization.

So I think this is not to say there is nothing there. There is more on hospitals. There has been very little on ambulatory care that HCFA has traditionally been able to get from physicians' offices and from ambulatory care outside, but they are trying to do the best they can. It really is not a very comparable set of information.

Mr. BILIRAKIS. Is the bottom line of all this the question of is there as much emphasis on the part of HCFA with regard to quality for fee-for-service plans as there is for managed care plans?

Ms. WILENSKY. You don't have the ability to hold an organization accountable in fee-for-service that you do have in a risk plan. That's why hospitals have been easier to hold accountable, and almost all of the focus of the PRO's, the previous PSRO's, have been on the hospitals. It has been very difficult to some up with a set of instruments, of requirements to try to get information on quality for individual physicians, because so much of what happens may not be just that one individual physician, but other things going on. HCFA is trying hard to——

Mr. BILIRAKIS. So Dr. Ganske's point about information being disseminated to providers, et cetera, is true. It also goes out to fee-for-service providers, as well as to managed care providers. But in terms of the gathering together of data in terms of how successful they have been, it's easier insofar as managed care plans are concerned.

Ms. WILENSKY. It's of a limited nature and, after all, Dr. Ganske, as a surgeon, was doing much of his activity in an environment in which HCFA was already focusing because it was institutional.

It would be much less true, for example, for people who practice mostly in their office, who are doing internal medicine and primary care, just because the primary focus of their interaction with the patients is in their office and not in the hospital, which is where HCFA's focus——

Mr. BILIRAKIS. That makes sense. I want to continue on here and hopefully, we can revisit this, but let's make sure we get through here before we have those votes. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

Dr. Feder, welcome back to the committee, nice to see you.

Ms. FEDER. Thank you, Mr. Brown.

Mr. BROWN. We heard Deputy Administrator of HCFA, Mike Hash, earlier describe some of the ways that HCFA has become a smarter purchaser.

In your testimony, you touched upon some of those administrative responsibilities. You said that promoting quality is especially important in managed care plans because these plans limit the providers and the services that enrollees can access. Would you elaborate on that.

Ms. FEDER. Absolutely, and I am glad to, because I think it's an appropriate follow-on to what we were just discussing. It clearly is critical that quality be promoted throughout the program. But the difference between managed care plans and the fee-for-service system is that managed care plans may limit the providers or the choice or providers that beneficiaries have, so fee-for-service has a very important protection that managed care lacks, you can vote with your feet. That really helps consumers.

In addition, the managed care plans are deciding on the specific set of services, specific course of treatment, and may limit benefits in ways that do not occur in the fee-for-service system. So while quality assurance is important throughout the program, it is extremely important in the managed care environment where consumers have less recourse to move.

Mr. BROWN. Thank you.

Mr. GANSKE [presiding]. I guess it's my turn, since I'm now in the chair. It would have been, anyway.

It's good to see you again, Dr. Wilensky. In your testimony, you reiterated prior research, including some excellent work done by MedPAC, on the extent to which Medicare is overpaying risk plans.

Dr. Feder indicated that these historic overpayments provide plans "with a strong cushion to absorb lower rates of increase in the future and still earn healthy returns." Would you agree with that statement?

Ms. WILENSKY. I think the behavior of the plans makes me uneasy empirically that her statement is true, and I would like to explain to you what the PPRC and MedPAC data has said. I don't disagree with the conclusion that the information suggests on average that healthier people join plans.

But it's really important that the members of the committee understand what the data said. Several of you have referenced it, and as Chair of both the current commission and as a former researcher, let me explain what we said and what we didn't. What we know is in the year before somebody joins an HMO, they've had less health use. The reason that becomes important is some plans—what we know, we don't actually know much about their health status. What we know is in the year before they join the HMO, people who joined an HMO used less health care than people who were staying in fee-for-service.

Now, we presume it was because they were healthier. It also may be that they are people who don't like to use health care as much as others, or who have some other characteristics about themselves. But generally, we assume the fact they were using health care less——

Mr. GANSKE. Dr. Wilensky, do we also know that people who leave HMO's consume more health care?

Ms. WILENSKY. Yes, immediately in the time period.

Mr. GANSKE. And that's the differential between, say, roughly 65 cents for an HMO enrollee, as compared to $1.00 for an average fee-for-service, and $1.65 for a disenrollee, as compared to $1.00 for——

Ms. WILENSKY. That's correct. Now, let me explain.

Mr. GANSKE. You would not disagree with that?

Ms. WILENSKY. No, no. Well, they were the commission that I was chairing, their numbers. No, I don't disagree, but let me explain what they mean, because I'm not quite sure that your members understand exactly what that data show.

This is when you go in. Most people who go in stay in. We know very little about what happens to people as they are in an HMO over time, and furthermore, some of the HMO's have mostly people who have been there a long time, like some of the Minnesota plans and some of the Oregon plans. Other plans have mostly new people coming in and they are probably, in fact, mostly healthy.

So the fact that we know a lot about what happens just before they went in doesn't mean we know very much about they health status of people who have been in there 1 year, 3 years, 5 years. And especially those who have mostly new members, as opposed to those who have a good mix of longtime members, maybe from when they were under 65.

You asked about the flip side, about the 4 percent who go back to fee-for-service. Yes, in the time they immediately leave, they use a lot of health care. And we don't know whether when they are going back, it is because there is something they want out of the system, more home care, a particular physician who isn't a part of a risk plan, or whether or not their plans may have gently suggested that they might find their care more appealing elsewhere.

But again, this is for 4 percent. And the major numbers of people stay there. It's why it makes us very hard for us to know, as we get more members, whether or not what we knew when the plans were new and young is still going on. So I only caution you to understand that there is an awful lot about the people who stay in, who are aging, who we don't know. It makes it a little more complicated.

Mr. GANSKE. I want to ask one more question of Dr. Feder. But I just want to summarize, Dr. Wilensky, your statement. And your statement was that you do not think that Congress should go back and change the funding.

Ms. WILENSKY. I do not think Congress should go back and change the funding, that is correct.

Mr. GANSKE. Okay. Dr. Feder, you began your written statement with the observation that claims from the industry that payments are too low should not derail Congress from its obligations to protect taxpayers and beneficiaries. I thought that was a very, very pertinent comment. And that is simply that it's not Congress' job to ensure HMO survival; it's Congress' job to make sure that Medicare beneficiaries get good quality care and that the system doesn't go broke.

Ms. FEDER. Absolutely.

Ms. WILENSKY. I agree with that, also.

Mr. GANSKE. Are you saying, in effect, that until it can be demonstrated that Medicare+Choice plans actually save the program money, that we shouldn't shed too many tears that some are leaving the market?

Ms. FEDER. Well, I think we have to watch when people are leaving the market, particularly because the beneficiaries are getting hurt in the process. But I think, as you said, our job is to protect the beneficiaries, not to protect particular plans.

Mr. GANSKE. All right. Well, the representative for Blue Cross Blue Shield, and I think I am not misrepresenting what he said, said to date, one or two plans may leave Medicare Risk out of 50 or so. But then he went on to say that more could leave. Is that crying wolf?

Ms. FEDER. Well, I think when I said we haven't even begun here, I think it is a little bit premature to make assumptions about how dramatic the problems are. I guess I would add to that, if we look at the private sector experience, and in the last few years, the aggressive premium constraints that some private purchasers were placing on managed care plans; and look at the growth we saw in managed care in that period, it seems they have stayed in the private sector to perform. So I think I would be cautious about assuming they are going to leave, No. 1, and if they can't do the job, I'm not sure you want them to stay.

Mr. GANSKE. All right. My time has expired and I am going to recognize Mr. Pallone, who I want to thank for your question earlier today, which I thought was very, very pertinent. That had to do with the fact that, in essence, a representative for the managed care industry would not answer your question, danced around a lot on the question of whether "is it not true that you are providing more benefits and now you are saying that if you aren't paid more, you are going to get out?"

I mean, why not address the basic benefits package in the first place, and make it equitable across the board. I thought that was a very, very pertinent question, and I thought it was very interesting that the representative for the industry simply would not, in a straight yes or no fashion, answer that question.

I yield to the gentleman from New Jersey.

Mr. PALLONE. Thank you, and thanks for all your help, too, with the Patient's Bill of Rights.

I realized, as I was asking some of the questions that Dr. Ganske mentioned, that Congressman Pete Stark had basically approached the same issue. I guess this was at a Ways and Means hearing, so I wanted, if I could, Mr. Chairman, ask that the statement from Congressman Stark be entered into the record.

Mr. GANSKE. Without objection.

[The prepared statement of Hon. Pete Stark follows:]

PREPARED STATEMENT OF HON. PETE STARK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

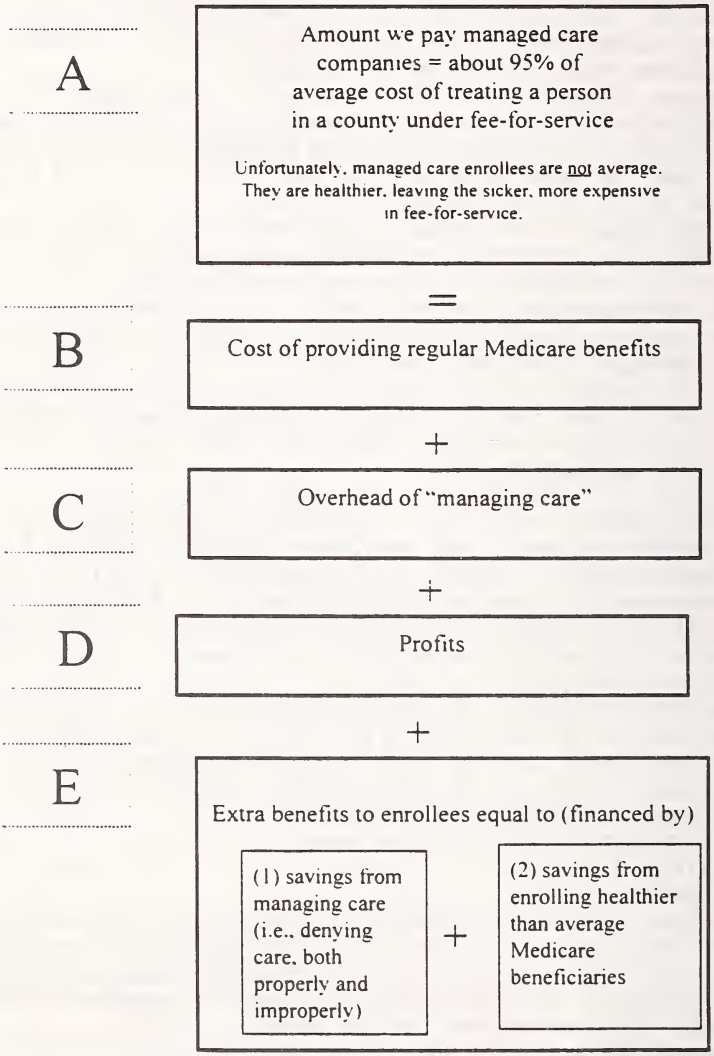
Mr. Chairman: Congress faces an irreconcilable dilemma in Medicare and managed care:

—We are losing money on Medicare managed care (see attached documentation), especially in rural areas, compared to Medicare fee-for-service, because we are overpaying them;

—If Medicare tries to save money in managed care, the plans will cut back on the extra services (especially pharmaceuticals) that we'd all like to provide to seniors and the disabled.

Because the Balanced Budget Act finally began to try to save money in Medicare managed care, we are facing this storm of Plan cutbacks—and it will get worse as the risk selection and other provisions of the BBA kick-in.

The problem can be explained somewhat mathematically:


A
Amount we pay managed care companies = about 95% of average cost of treating a person in a county under fee-for-service
Unfortunately, managed care enrollees are not average. They are healthier, leaving the sicker, more expensive in fee-for-service.
=
B
Cost of providing regular Medicare benefits
+
C
Overhead of "managing care"
+
D
Profits
+
E
Extra benefits to enrollees equal to (financed by)
(1) savings from managing care (i.e., denying care, both properly and improperly)
+
(2) savings from enrolling healthier than average Medicare beneficiaries

In rural America, the cost of the overhead of setting up a network of providers (C) is fairly high compared to the savings from "managing care" (E1), and therefore, to maintain profits the plans have to cut the extra benefits that we all want to provide our constituents.

We can keep providing our constituents the extra benefits if we are willing to keep spending more per person on Medicare managed care than we do on Medicare fee-for-service per person. It is awkward that some of the extra money we would spend on the plans would go to feed the multi-million dollar salaries of their executives and their political contributions (D).

I also am resentful that so much of the current extra cost of Medicare managed care plans is because they work so hard to avoid enrolling really sick people who need comprehensive health care (E(2)); throwing more money at these largely for-profit plans just allows that behavior to continue.

We can also help the plans provide these extra benefits, if we weaken the quality and anti-fraud standards (i.e., reduce the cost of providing care (B)). That is like saying we can lower airfares if we stop requiring so many safety inspections—it is not a road I want to go down, because a bad quality plan will kill people just as surely as a badly maintained airplane.

As health care costs continue to rise (they are predicted to double over the next decade), and as the risk adjustment provisions of the BBA go into effect, the plans will continue to scale back the extra benefits (E) they offer our constituents. We will be under constant pressure to give them more money (A)—even though Medicare faces long-range financial problems as the Baby Boomers retire—or scale back our demand for quality benefits (B).

Is there an answer?

Yes!

Decide what benefits we really want to guarantee *all* our constituent (not just those who enroll in a managed care plan or who can afford the ever-more-expensive medigap policies), add them to the Medicare benefit and pay for it through increased and progressively—applied premiums or taxes.

For example, if we added a prescription drug benefit to Medicare (a bill I will soon be introducing), we could use the purchasing power of the Federal government to get a good price, eliminate the wasteful overhead of managed care and medigap plans, and guarantee the benefit to *everyone*, thus reducing pressure on seniors to join managed care plans and helping beneficiaries in rural America.

Some will immediately scream "taxes!" But what do you think we are doing now? We are taxing all Americans more than the cost of regular Medicare to provide *some* beneficiaries who enroll in managed care plans with extra (but utterly undependable) benefits. It is an irrational, haphazard way of dealing with what is a national problem facing *all* beneficiaries.

We should have a debate on what should be in the national Medicare benefit package. Anything else is just a distraction from the main problem of providing a quality, modem health plan to all our constituents.

CURRENT MEDICARE OVERPAYMENTS TO MANAGED CARE PLANS

SOURCE OF OVERPAYMENT	COST TO MEDICARE	SOURCE OF ANALYSIS
Overpayments due to BBA change that removed HCFA's ability to recover overpayments when health care inflation is lower than expected.	$800 million in 1997 $8.7 billion over 5 years $31 billion over 10 years	Congressional Budget Office
Overpayments due to lack of risk adjustment.	5-6% overpayment to HMOs per beneficiary who is enrolled.	Physician Payment Review Commission (now MedPAC) 1996 Annual Report
Overpayments due to inflation of Medicare's share of plan administrative costs.	More than $1 billion annually	HHS Office of Inspector General July 1998
Overpayments due to inclusion of fraud, waste and abuse dollars from FFS payments. Managed care plans should better "manage" and therefore avoid such fraud, waste and abuse.	7% annual overpayment Annual savings with a corrected 1997 base year would be:. $5 billion in 2002 $10 billion in 2007	HHS Office of Inspector General Sept. 11, 1998

Prepared by the Office of Rep. Pete Stark.

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
February 12, 1997

Dear Colleague:

Medicare loses money on every person who signs up for a Medicare HMO, and the President's budget proposes to make changes in the program so that managed care finally fulfills its promise of saving money for Medicare.

The attached summary of studies describes how HMOs tend to sign up healthier people and under the current payment system, Medicare pays the HMOs too much.

The one study which gave a different answer was funded by the HMO industry, and even that data now shows Medicare HMOs are not savers.

This is not rocket science: sick and disabled people who want to be able to see a lot of doctors and go to specialists are unlikely to want to join a plan which tries to control that access. We need to pay HMOs less—not more—if Medicare is going to save money from managed care.

Sincerely,

PETE STARK
Member of Congress

SUMMARY OF STUDIES ON SELECTION BIAS IN MEDICARE HMOS [1]

INTRODUCTION

Selection studies address whether enrollees in Medicare risk plans differ systematically from those beneficiaries who remain in fee-for-service. Because payments to managed care plans are based on the average costs of beneficiaries In FFS in that county after controling for demographics, Medicare will overpay HMOs. If the health status of enrollees is better than the health status of fee-for-service (FFS) beneficiaries; likewise, Medicare will underpay if HMOs enroll a mix of enrollees who are sicker than the average FFS beneficiary.

There have been a number of studies addressing the extent to which HMOs enroll a healthier or less healthy population, compared to beneficiaries in fee-for-service. All but one study found that HMOs experience favorable selection using a variety of health status measures; that is, beneficiaries enrolled in HMOs experienced lower costs prior to enrollment in the managed care organization, were found to have better functional health status, had fewer chronic diseases, or experienced lower morality rates than their FFS counterparts (Riley, et al., 1996; PPRC, 1996; Brown, et al., 1993; Lichtenstein, et al., 1991; Riley et al., 1991). After its initial release, the single conflicting study (Price Waterhouse, 1996) was updated with different results. All these studies are briefly summarized below.

SUMMARY

Riley et al., (1996) assessed health status differences between enrollees and non-enrollees during the period of enrollment in the HMO. Survey data from the 1994 Medicare Current Beneficiary Survey (MCBS) were analyzed for 863 HMO respondents and 4,576 respondents in FFS. After controlling for factors incorporated in the AAPCC, the study found that HMO respondents were significantly less likely to report fair or poor health, functional impairment, or heart disease than respondents in FFS. In addition, the study used a cost prediction model which compared predicted FFS payments to predicted HMO payments to provide an estimate of how much Medicare saved (or it overpaid) for HMO care under the AAPCC. When several dimensions of health status were controlled for in addition to AAPCC factors, the average predicted costs of HMO enrollees were only 85 percent of average predicted costs for respondents in FFS. The analysis suggests that, when applied to actual HMO enrollees, the AAPCC may be 14 percent too high because the better health status of HMO enrollees is not adequately accounted for, and that Medicare is experiencing losses of about 8 percent on its risk contracting program, rather than saving 5 percent.

The Physician Payment Review Commission (PPRC) (1996) conducted a study using Medicare claims data from 1989 to 1994. The analyses looked at three groups: beneficiaries who entered an HMO and remained enrolled; those who entered and subsequently disenrolled, and those who were continuously enrolled in FFS Medicare. Total expenditures were compared across groups. The results showed that spending by new HMO enrollees was about 63 percent of that for beneficiaries in the FFS control group during the six months before they joined an HMO. Beneficiaries who stayed enrolled in the HMO had the lowest preenrollment expenditures, averaging about 56 payment of the FFS control group. For the post-disenrollment period, beneficiaries who left HMOs experienced higher spending compared with the FFS group. That is, expenditures were 60 percent higher for HMO disenrollees than for the FFS control group in the six months after disenrollment. Thus, PPRC found evidence for both selective enrollment and selective disenrollment. That is, persons enrolling in HMOs tended to be healthy and those disenrolling tended to be unhealthy, thereby exacerbating the problem of favorable selection.

[1] This summary is limited to studies using data from the period 1987 to 1996.

An early evaluation of the Medicare risk program, conducted by Mathematics Policy Research (MPR) using data from 1987 to 1990, concluded that enrollees in managed care were in better health than nonenrollees (Brown et al., 1993). Compared with nonenrollees, HMO enrollees were found to have fewer functional impairments, and they were less likely than nonenrollees to report poor health or a history of cancer, heart disease or stroke. MPR determined that if managed care enrollees had received services through traditional Medicare, the average costs would have been $2,344. The average actual FFS cost for nonenrollees, adjusted to account for demographic differences between the enrollee/nonenrollee populations, was $2,608. Thus, the adjusted cost for non-enrollees was 11.3 percent higher than the predicted cost for enrollees. This translates into a 5.7 percent increase in coss to Medicare, given that payment is made at 95 percent of the AAPCC.

Lichtenstein et al., (1991) addressed selection bias using data from a nonrandom sample of 22 HMOs, located in 12 cities, that enrolled Medicare beneficiaries under TEFRA risk contracts. A questionnaire was mailed to each of 10,035 beneficiaries participating in the study. For each of the participating HMOs, the functional health status of recent Medicare enrollees was compared with that of a control group of randomly chosen FFS beneficiaries. None of the HMOs experienced adverse selection, whether measured in terms of overall average functional status of enrollees or in terms of the proportion of the very disabled population that chose to join. Nine of the 22 HMOs were considered to have experienced favorable selection on the basis of the average health status of new enrollees.

Finally, Riley and his colleagues (1991) analyzed 1987 mortality data for 1 million beneficiaries enrolled in 108 HMOs. The researchers estimated adjusted mortality ratios (AMR) for each HMO and across all HMOs, by dividing the actual number of deaths among HMO enrollees by the expected number of deaths, adjusted for demographic factors in the AAPCC. The average mortality ratio for all HMO enrollees was .80, implying that mortality among HMO enrollees was 20 percent lower than in FFS. For new enrollees to managed care, the AMR was 0.69, indicating that the mortality level was 31 percent lower than in FFS. Among individual HMOs, none showed an AMR substantially above 1.00.

One conflicting study also addressed selection using MCBS data. Price Waterhouse (P/W) (1996) evaluated biased selection and the impact on Medicare costs using data from an earlier round of the MCBS than that used in the Riley et al., (1996) study. The authors constructed a sample of 371 Medicare risk enrollees and 1,629 FFS beneficiaries using Round 4 data from the MCBS, conducted in 1992. They matched each Medicare risk contract enrollee with all of the FFS beneficiaries in the same county who had identical demographic cost factors, according to the AAPCC payment formula. The P/W results showed that risk contract HMO enrollees were slightly healthier when asked about their general health than the FFS control group, although both groups had the same proportion of persons in the poorest health category. Levels of functional status were similar between the two groups. Using a two-part cost prediction model (first to predict the probability of having non-zero spending and second to predict actual Medicare expenditures), the study found that actual costs for the FFS group were $242 per month, compared to predicted costs for the HMO risk group of $252. The authors concluded that there was no cost difference between the risk HMO population and the FFS sample after controlling for AAPCC factors. However, preliminary findings from a replication of the Price Waterhouse study using 1994 data from the MCBS, found evidence of better health status and lower costs among HMO enrollees (Burner and Riley, 1996).

The summary of the recent findings on selection into HMOs suggest a consistent pattern of findings; that is, enrollees in HMOs are generally healthier than their fee-for-service counterparts. This pattern is found whether measured by pre-enrollment costs for HMO enrollees, health status differences between enrollees and beneficiaries in fee-for-service, or mortality differences. Studies of post-disenrollment costs suggests that enrollees who disenroll within a relatively short period have higher than average post disenrollment costs, thereby increasing the problem of favorable selection.

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Mr. PALLONE. Thank you. Just so I understand, and it kind of goes along the same vein here, Dr. Feder, again, you can tell that I wasn't that hot on the idea that somehow by encouraging HMO's, we were going to necessarily get expanded benefits. I am sort of convinced even more that that's not the case.

Based on what you said, which was such an optimistic view sort of, stay the course and things aren't that bad, do you really envision that, under the existing program that we've legislatively laid out here with the Balanced Budget Act, that these plans are going to be able to offer extra benefits. You don't see them cutting back?

I am worried about them dropping out completely, but I am even more worried about them staying in and not offering the benefits that they promised and cutting back on those benefits.

Ms. FEDER. Right. I guess the reason for the strength of my statement, Mr. Pallone, is that I think it's appropriate to call attention to what seems to be the plans' first line of defense when they face a premium constraint. I think it ought to be consistent with the arguments that the plans and their advocates make. Their first line of defense ought to be to promote efficiency in the management of care for Medicare patients.

Instead, the first claim that they make is that they are going to reduce the benefits. So I think we ought to shine a bright light on what managed care plans ought to do and hold them to managing care. I think that is a part of what is being done in the program with the standards for the plans.

Beyond that, I think that your concern or your questioning the issue of how to get better benefits, which Medicare beneficiaries sorely need, to them; to question whether the managed care strategy is the right way to do that. The more we constrain costs in the overall program, the less we can expect the capitation rates to be able to provide those extra benefits.

I think it's clear that the right way to do this is for Medicare to review its benefit package and to protect people better because the benefit package is quite limited for beneficiaries throughout the system. So I share your concerns, but I think we ought to hold the managed plans' feet to the fire.

Mr. PALLONE. So then you actually are not that concerned that a lot of these HMO's are going to drop out of Medicare. You think that maybe is a short-term problem, but over the long term we'll probably get some good participation. You are more concerned—well, you can answer that.

Ms. FEDER. At the moment, I think it's premature to make specific predictions, but I think that as we constrain rates in the program as a whole, the extra benefits may come into question. I also thought that what you were raising was a legitimate point, that I believe it to be true that for the program as a whole, plans are not finding themselves inadequately paid for the basic Medicare package. I think you were quite right about that.

Mr. PALLONE. All right, I appreciate that. Just a comment before I end, the problem is that when you talk to seniors when you are at your forums, their main incentive for joining HMO's is because they think they're going to get extra benefits, either prescription drugs or not have to pay a copayment or whatever. So if we don't deal with that, which is sort of the promise of all this, then we are not being very successful. So that's why I put the emphasis on that, as opposed to whether they are in or out of the system.

Ms. FEDER. And I think you are right, that the commitment ought to be across the board to adequate protections for seniors in whatever plan, traditional Medicare or managed care plans, that the benefit package ought to be adequate to protect them. And we know, in the traditional system, it's not right now.

Mr. PALLONE. Okay. Thank you.

Mr. GANSKE. Anyone have further questions? Well, then I want to thank the guests for being patient.

Mr. BILIRAKIS. Just one quick one, Mr. Chairman, if I may. My time ran out before I could ask it.

Dr. Feder, you certainly expressed concern, I think you made the comment that BBA 97 afforded HCFA the adequate opportunity to continue to be an important part of the process. But one of the concerns that we heard from other witnesses today was the overregulation. I referred to it as the megareg.

Ms. FEDER. Megareg.

Mr. BILIRAKIS. Was there a need for an 800-plus page set of regulations? I don't know whether, in my absence, this was addressed especially. Considering that these plans had already been regulated, approved, and oversight had taken place over a period of time.

Very, very briefly, I don't want to take up much time, if you both maybe would give me your opinion.

Ms. FEDER. First, I am not sure that the page number in the regs is exactly right.

Mr. BILIRAKIS. I think it's more than that.

Ms. FEDER. I don't know. I wasn't sure in the regulation itself, but I think the real point here is you can't have a market system, a choice system, without oversight. Otherwise, what you end up with is a waste of the taxpayers' money. You don't know what you're buying and you end us with risk selection with healthy people going one place and sick people going someplace else.

You need an oversight system. I think that HCFA has done the job it ought to be doing. I think it also has inadequate resources to do that job. So my concern is on securing that oversight system, not nitpicking about the number of pages. That may be appropriate guidance.

Mr. BILIRAKIS. May be appropriate guidance. Dr. Wilensky.

Ms. WILENSKY. This is a very regulatory approach. HCFA has some discretion about whether to go as much regulation as the law would allow, or to do the minimum that is consistent with the law. And there is usually a lot of discretion in between those two points.

I think you can assess what HCFA has put out as taking a very regulatory attitude with regard to the Balanced Budget Act, not outside the scope of the Act, but sometimes going farther than at least was necessary to meet the requirements of the Act.

I do think the concern of the committee ought to be whether or not the kinds of choices that you thought would be available to seniors will, in fact, be there. And to remember that at least now, unless you are willing to put more money in the Medicare program, what you are suggesting is that if the kind of risk plans or the new kinds of risk plans aren't, in fact, going to be available, then most of these people will end up being in $1,500 to $1,800 a year medigap plans.

If there's a way to try to help, not by putting more money in the pot, which I do not suggest that you do, but by seeing whether or not there may be either dateline accommodations, this issue about whether May is particularly troublesome, but July or August might allow plans to have more information than they had early on—I'm not questioning whether they ought to have known or should have known or did know earlier—but whether there may be ways to try to accommodate what are being raised as serious issues without just throwing in more money, is something I think ought not to be regarded as dismissively as, it seems to me, we have regarded it to date.

To the extent we don't see the growth in opportunities, you will probably find yourselves under a lot more pressure to have the Medicare program expand its dollar coverage in terms of what used to be provided by some of these other opportunities.

You may feel that is the appropriate thing. If you can come up with the money, of course, you are welcome to propose that. It doesn't seem that's the direction that the Congress thinks they are going with the aging population.

Mr. BILIRAKIS. Thank you.

Mr. GANSKE. And I will make one final comment, Mr. Chairman. That is that we really didn't get in today—you started to ask a question to Mr. Gradison on why haven't MSA's really taken off. My office has been working on this quite a bit. I think it would be a good thing sometime for this subcommittee to have a hearing and bring in some of the insurance industry players on this.

It appears to me that there may be at least some evidence that because you generally can earn less on a higher premium policy, that there may have been—and there are some problems with determining exactly who manages that savings account and the return on it, I think there's been some reluctance or disincentives on the part of some insurance companies to really provide equity to their consumers in offering that product.

It would be the subject, I think, of a very interesting on hearing.

Mr. BILIRAKIS. Well, I agree. I made light of it only because I went through it very quickly and it wasn't really specifically on point in terms of today's hearing. But I am concerned that that concept is not taking off the way we all envisioned that it might. So it is something we should continue to address. Thank you.

Mr. GANSKE. Dr. Wilensky and Dr. Feder, thanks for coming.

[Whereupon, at 1:40 p.m., the subcommittee adjourned subject to the call of the Chair.]

[Additional material submitted for the record follows:]

Prepared Statement of The American Hospital Association

The American Hospital Association (AHA) represents nearly 5,000 hospitals and health systems, networks, and other providers of care. We appreciate this opportunity to present our views on an issue that is critical to the future of many of our members and their communities: the Health Care Financing Administration's (HCFA) rules for Medicare+Choice (M+C) plans, including provider-sponsored organizations (PSOs) and other plans offered by providers.

INTRODUCTION

Hospitals and health systems have a variety of interests in this matter. We have been strong advocates of PSOs because we believe they expand the choices available to Medicare beneficiaries. In addition, 20 percent of our members offer a health maintenance organization (HMO), and 30 percent offer preferred provider organizations (PPOs). In each case, almost double that number enter into managed care contracts with HMOs and PPOs. Clearly, hospitals and health systems across the country have a major stake in the success of the M+C program.

However, we have begun hearing some disquieting comments from our members about their ability to deliver on the promise of Medicare+Choice. Among these comments:

- *Offering a Medicare+Choice plan may simply not be feasible, especially for start-up organizations.* Program requirements have expanded significantly. At the same time, plan payments are undergoing major changes that may not yield rates sufficient to comply with HCFA's requirements and permit plans to offer a benefit package that would attract Medicare beneficiaries.
- *Interest in sponsoring Medicare+Choice plans is high among our members, but there are many reasons to be cautious.* Without better balance between the Medicare program's demands and what Medicare pays, far too few of our members and others will offer plans. The fact that so many existing risk contractors are scaling back or withdrawing their Medicare plans has led to greater caution on the part of potential plan applicants.
- *Lack of certainty, or at least some measure of predictability, regarding how requirements will be interpreted by HCFA and the actual payment amount that will be made, have made it extremely difficult for potential applicants to develop sound business plans and applications.* We recognize the burden that the Balanced Budget Act of 1997 (BBA) has placed on HCFA's staff resources. Our members, too, are suffering the consequences of implementing the numerous changes required by the BBA. However, the agency's inability to issue guidance on a timely basis, its reliance on unfinished methodologies, and its inability to resolve basic operational implementation problems, are seriously undermining the ability of organizations to offer plans. That is especially true in areas of the country with little or no access to alternative plans.

The AHA believes that these problems have emerged because the federal government, in attempting to take advantage of the marketplace to expand options to beneficiaries, has not yet accepted the lessons of the marketplace. That lesson: Purchasers must scale their demands to what they are willing to pay. While purchasers can push to obtain better value, pushing too far too fast may simply push organizations away from the market. AHA does not want this to happen.

We urge that HCFA reassess its decisions on implementing the Medicare+Choice program, and solve the practical problems that will ultimately determine the success of the program. Our testimony today includes many suggestions that we believe can help. These suggestions were discussed in greater depth in our September 24, 1998, letter to HCFA commenting formally on the interim final rules.

As we developed these suggestions, we found that the insights of PSOs that are participating in the Medicare Choices demonstration project were especially helpful. We believe the agency would benefit significantly from first-hand accounts of the practical difficulties in starting and maintaining plans offered by providers in their communities. We have told HCFA that we would be pleased to organize and host a meeting between key staff at HCFA and key executives at the demonstration sites. Without the benefit of such practical advice, we fear that many areas of the country will never have any alternative health plans from which to choose.

RECOMMENDATIONS FOR MEDICARE+CHOICE IMPLEMENTATION

The M+C program replaces the current risk-contracting program for health maintenance organizations (HMOs) and competitive medical plans (CMPs) and expands the options that can be made available to beneficiaries. Many of the requirements and standards in HCFA's interim rule were drawn from the previous Medicare risk

contracting program for HMOs and CMPs, but there are also several fundamental changes that are likely to affect the availability of new plan choices for Medicare beneficiaries, if not the viability of the program overall.

Whether the Medicare+Choice regulation is workable remains to be seen. It is an enormous rule that incorporates many changes in Medicare risk-contracting practices that will affect health plans, providers, and beneficiaries alike. However, the AHA and its members (both those that offer Medicare plans and those that do not) have evaluated these changes, and we believe aspects of the new program are likely to cause problems.

Rural Access to Medicare+Choice Plans

The new rules require that benefits, premiums, and cost sharing be identical throughout the entire service area. Previously, plans could vary these elements on a county-by-county basis. Because Medicare capitated rates vary, often significantly, from one county to another and most service areas encompass more than one county, there is a problem: It is difficult to provide the same benefit throughout a service area without getting the same or similar Medicare capitated payment for everyone in that area.

Plans have three basic approaches available to resolve this problem under the new rules: 1) reduce benefits in higher rate areas to cross-subsidize lower rate areas; 2) pull out of lower-rate areas; or 3) seek HCFA approval of multiple M+C plans offered by the same M+C organization.

The first of these approaches is not viable from a competitive perspective unless the rates for counties within the service area vary only a little. Plans will have to offer benefit packages that are competitive in the highest-rate county within their service area.

With respect to the second approach, we are already hearing reports from around the country that major HMOs are pulling out of rural portions of their Medicare service area.

The third approach is one that is newly available under the rules and is subject to a great deal of HCFA discretion. Consequently, its availability as a solution is uncertain. Furthermore, offering multiple plans may create another problem—increased administrative cost.

While we have no doubt that these requirements were intended to avoid discrimination against certain Medicare sub-populations, we fear their effect may be much broader—killing access to health plan alternatives in rural areas.

Recommendation: **HCFA should modify the benefit design and service area rules to reflect the underlying rates available. At best, the flexible benefits approach should be reinstated. If that is not possible, multiple plans should be allowed to split service areas that have significant variations in rates from county to county. To reduce the administrative cost of multiple plans, HCFA should maximize assessment of compliance with Medicare requirements at the Medicare+Choice organization level, and minimize compliance assessment at the individual plan level.**

In addition, our discussions with the Medicare Choices demonstration projects identified two problems with efforts to increase rural access. In one case, HCFA has prohibited a planned service area expansion to include several additional rural areas, because the providers in those areas lack experience in providing managed care—even though the plan itself does have experience. We will never accomplish the goal of making coordinated care plans available in rural areas if we do not allow collaboration among experienced providers/plans and inexperienced rural providers.

Recommendation: **To promote the availability of choices in rural areas, HCFA should adopt a more flexible approach to assessing the ability of existing plans to expand into rural or underserved areas.**

On a similar issue, several demonstration projects also are experiencing difficulty obtaining timely review and action on requests for service area expansions. Generally, these expansions were part of their business plans and the inability to expand may jeopardize these start-up organizations that must increase their enrollment base to support start-up costs.

Recommendation: **HCFA should place greater priority on reviewing and acting upon service area expansion requests, especially when they are part of the basic business plans that are reviewed when contracts are granted.**

Premature Implementation of QISMC

M+C organizations are required to have an ongoing quality assessment and improvement program based on the Quality Improvement System for Managed Care (QISMC). QISMC was created by state and federal regulators in an effort to develop

and apply consistent standards for managed care plans under Medicare and Medicaid. There are two primary requirements in the regulations:

1. Measurement and reporting of performance, which includes measuring and reporting on HCFA requirements as well as achieving any minimum performance levels that may be established locally, regionally, or nationally by HCFA.
2. Conducting, according to HCFA's rule, "performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of both clinical care and non-clinical care areas that can be expected to affect health outcomes and member satisfaction."

This is a dramatic new approach to quality assurance under the Medicare risk-contracting program—one that we believe exceeds the expectations of the drafters of the BBA. The regulations also do not reflect a key transitional provision that was in the original QISMC proposal: that plans must be given the first two years under the new standards to build and refine the quality assessment infrastructure, before moving to quality improvement initiatives. If plans are required to move immediately to quality improvement initiatives, the building of strong quality assessment mechanisms may suffer.

Instead of holding plans responsible for the quality of their services, QISMC holds them responsible for the health status of their enrollees. This could cause problems for several reasons:

- Currently, there are few direct links between specific outcomes and defined changes in the care process.
- Health plans have limited or no impact on many of the factors that affect enrollee health status: poverty, lack of family support, inadequate housing, etc.
- Holding plans accountable for sustained improvement will discourage them from performing quality projects that address more complex problems that may not show much initial promise for improvement. The effect of improvement initiatives needs to be measured over a longer term—generally two to three years.

Quality improvement is an appropriate goal—one that we support. However, it cannot be accomplished overnight. As hospitals and health systems, our members are among the most experienced in the development and evolution of quality programs. We know the dangers of jumping too far theoretically without resolving practical issues of how to achieve goals. We understand that HCFA has scaled back the number of projects they expect health plans to initiate, to two per year for Medicare and one for Medicaid, compared to the full QISMC proposal, but we believe that change is still insufficient.

Recommendation: **HCFA's approach should be revised to significantly improve flexibility and avoid a potential meltdown at both the plan and provider level. The AHA recommends that HCFA:**

- Further limit the number of required quality improvement initiatives, especially during the first several years, in two ways: 1) require only one new initiative each for Medicare and Medicaid each year, and 2) limit to four the number of active initiatives required at any given time.
- Clarify that health plan-level quality programs should be directed toward improving the care processes that are likely to affect the health status of enrollees. It also should be recognized that health plans work with providers, but they do not have direct control of care processes. The distinction between plan and provider roles needs to be clarified.
- Not apply the "demonstrable and sustained improvement" standard so rigidly that Medicare+Choice plans are forced to focus only where the connection to improved health status is already established, and avoid focusing on areas where we need to better understand which types of interventions actually improve health status or enrollee satisfaction.
- Provide a forum (whether through local peer review or other organizations) to coordinate individual plan initiatives, the data collection that supports those initiatives, and Medicare and Medicaid requirements for the initiatives. In areas where there are multiple Medicare+Choice plans, health care providers could be overwhelmed with the number of initiatives they would be expected to support simultaneously, especially if those initiatives require specialized data collection. Such forums should also allow Medicare+Choice organizations to know up front whether their planned initiatives are acceptable to Medicare and Medicaid.
- Establish criteria for selecting organizations to create this forum for coordination and collaboration. Such criteria should include appropriate clinical expertise, statistical analysis expertise, and quality improvement operational experience and expertise.

- Address the cross-relationship between these requirements that focus on quality improvement and those reflected in the proposed sixth scope of work for peer review organizations (PROs) that are described as "national health improvement priorities." The two directions appear to be independent of one another, which is likely to cause operational compliance problems at the plan and provider levels.

Confidentiality

In its rule, HCFA states that a M+C organization may not circulate patient-identifiable information outside the organization without specific authorization from the Medicare enrollee. Important research projects would not be feasible if the organization were required to obtain permission from every single subject. That is one reason that the federal institutional review board (IRB) process was established.

Recommendation: **Research should be specifically excluded from the requirement to obtain individual release authorizations, and parameters should be established for such research uses to protect individually identifiable information. These parameters should include internal safeguards, prohibitions on re-disclosure, and incentives to encrypt (or code) information. This is the approach taken by the National Association of Insurance Commissioners in its standards, and in most congressional legislation on this issue.**

Notice of Non-Coverage

The rule states that a Medicare+Choice plan enrollee is entitled to inpatient care until he/she receives a notice of non-coverage (NONC). This policy makes clear that the admission had to be authorized by the Medicare+Choice plan unless it is for emergency or urgent care, and that the policy will apply not only to coordinated care plans, but also to private, fee-for-service plans and medical savings account plans, where deductibles must be met. While beneficiaries can pursue an appeal of the discharge through the PRO or the plan, HCFA urges enrollees to go to the local PRO. If the enrollee requests a PRO review by noon of the day following receipt of the NONC, he/she incurs no financial liability for the next 72 hours and may remain in the hospital until noon of the day following the PRO's response.

The inclusion of this issue in the rule is important because in May 1998, HCFA ostensibly clarified an earlier policy that said all risk plan enrollees should be given a NONC before discharge, effective July 1, 1998. While this may have been the official policy, in practice only those discharges in dispute were given the notice, according to the American Association of Health Plans and Kaiser Permanente (Northwest). This resulted in less than one percent of discharged beneficiaries receiving a NONC.

This policy raises a number of concerns:

- *It is an unfunded mandate on hospitals.* Plans have already begun shifting NONC responsibility to hospitals through the general terms of their contracts, often without compensation.
- *It interferes with the appropriate transition among levels of care.* The automatic three-day extension of hospital stays pending PRO review of the discharge decision will inappropriately delay the transition of patients from one level of care to another. Besides the provision's financial impact, the delay could affect a patient's recuperation (e.g., when moving from inpatient surgical service to skilled nursing or outpatient rehabilitation).
- *There is no model language.* HCFA has provided no model notice of non-coverage for health plan use. This is a problem for both the plans and the hospitals with which they contract. In the absence of model language, plans may not be able to determine whether they are actually in compliance, and there are no ground rules regarding their expectations of hospitals and who should bear the cost of the process. From the provider perspective, lack of uniformity of the NONC could become a paperwork nightmare for those hospitals to which plans delegate this responsibility, especially when there are numerous Medicare plans involved. Furthermore, many plans are demanding that hospitals provide the necessary resources to meet these requirements, without compensation, and that the notices be placed on hospital letterhead, obscuring the fact that they emanate from the plan's coverage and utilization policies.
- *Beneficiaries may not like it.* The effect of these letters on beneficiaries could be very negative. Notices currently in use are often five to eight pages long and filled with complex, bureaucratic language that could easily confuse and anger beneficiaries, when they are already under stress from their illness. Many will ask, "Why am I getting this if my doctor told me it's all right to go home?" This

confusion and anger will be directed at the hospital, rather than the plan and its policies.

- *Staff resources will be taxed.* Hospital or plan staff must hand-deliver the notice and explain it to patients so they can understand before signing it.
- *Complete compliance is impossible.* There is no way to get 100 percent compliance, as many patients leave before the discharge planner, social worker, or other staff get to them during regular weekday business hours. In addition, our members question how these requirements can be met for emergency and out-of-area care.
- *There is a great incentive to appeal.* This notice could greatly increase the number of beneficiaries who appeal their discharges, especially if they are assured three additional days in the hospital at no cost to them. For example, appeals might be used by families wishing to postpone responsibility for care of a recuperating family member.
- *The cost of care could rise.* Patients who challenge a discharge can stay in the hospital an additional 72 hours. While it is the health plan's responsibility to cover such care, the cost could be borne by the hospital if, for example, the plan pays hospitals on a DRG basis.

Recommendation: **This policy needs to be rethought and significantly modified. The AHA has met with Robert Berenson, M.D., director of HCFA's Health Plans and Providers center, who has committed to addressing the problem. The AHA will work with HCFA to craft a notice that clearly outlines beneficiary rights of appeal, while avoiding paperwork overkill that will benefit no one. Because much of this information is already included in the "Important Message from Medicare," which beneficiaries receive at admission, that may be the vehicle of choice for information on the NONC as well. In addition, the NONC should not be given to every plan enrollee upon discharge, but only to those whose discharge status is in dispute.**

Mandatory Compliance Plan

The HCFA rule requires M+C plans to implement a formal, comprehensive compliance plan to ensure that the organization takes all steps possible to comply with applicable federal and state laws and regulations, including Medicare's rules and regulations on payment. We agree with the intent of this provision—helping the government cut down on waste and fraud in the health care system. The AHA's Board of Trustees passed a resolution encouraging our members to voluntarily adopt formal compliance plans. Hospitals and health systems have a zero tolerance policy toward those who would intentionally cheat the taxpayer.

However, we question HCFA's decision to mandate such a plan, on two counts. First, HCFA has mandated the implementation of a compliance plan in the absence of clear guidelines designed for health plans—although we note that the Health and Human Services Office of the Inspector General (OIG) published a notice on September 22 soliciting input on the development of such guidance. Second, we believe—and the OIG agrees—that voluntarily adopted compliance plans ensure the commitment of an organization to incorporate compliance into its culture. The voluntary nature of compliance also allows organizations to tailor a compliance plan to their individual needs. In the September 22 notice, OIG reaffirmed this position. The notice indicates that OIG intends to develop its guidance to Medicare+Choice coordinated care plans as voluntary guidelines despite the fact that the Medicare+Choice rules mandate adoption of a compliance plan with characteristics similar to other OIG voluntary guidelines.

The OIG is in the midst of issuing a series of model, voluntary compliance plan guidelines for the health care field. So far, guidelines have been issued for clinical labs, hospitals, and home health agencies. We worked closely with the OIG on its Model Compliance Program Guidance for Hospitals. The model will help hospitals establish better internal safeguards and processes to successfully comply with Medicare, Medicaid and other government health programs. We trust that the OIG's development of voluntary guidelines for coordinated care plans will yield a similar result.

Recommendation: **HCFA should not mandate compliance plans or the organizational mechanisms used to monitor and ensure compliance. Instead, it should simply mandate that Medicare+Choice organizations comply with applicable federal and state laws and regulations. HCFA should work with the OIG and interested parties to develop guidelines for health plans that would be applied in the same way as guidance for other voluntary compliance programs issued by the OIG.**

Plan Certification of Data Accuracy

The rule establishes a new requirement that health plans certify the accuracy and completeness of data submitted to support calculation of capitated rates and adjusted community rate (ACR) calculations. HCFA clearly identifies the purpose of this certification: extending the application of the False Claims Act to capitated risk contractors. It also requires that, where a plan subcontracts with others (including providers), each subcontractor must also certify the accuracy of encounter data they provide to the plan.

This approach of "no errors tolerated" is fraught with the same problems generated by its application to provider billing errors. It confuses purposeful fraudulent actions with simple error. Even in its contracts with Medicare fiscal intermediaries, HCFA provides an equal-or-lower-than five percent error margin.

This problem is even more acute because encounter-level data is included in this requirement. Discussion with the Medicare Choices demonstration sites, which must report the full range of encounter data, indicates persistent problems with the ability to submit encounter data to Medicare fiscal intermediaries. The fiscal intermediaries have been given no funds to support working out the operational problems and, hence, have no incentive to do so. With limited attention being devoted to resolving these problems, the demonstration sites are experiencing additional administrative costs and frustration, and we can expect the same problems across all the Medicare+Choice organizations as they expand their encounter-level reporting from just inpatient hospital data to all services.

Health care providers face additional problems as a result of this requirement. Will health plans seek contractual indemnification of the plan by the provider in the event the plan is penalized for inaccurate or incomplete data that was generated by the provider? What if the errors were introduced after data was submitted to the plan? How will responsibility be determined?

On a related issue, HCFA claims that it needs to audit the encounter data to ensure accuracy of the information. Any audit efforts will include medical record review for a portion of the submitted data. Who should bear this cost? Also, given the different medical necessity requirements between Medicare and private payers and even between regional Medicare carriers and intermediaries, we are concerned that health care providers will be confronted with competing demands about how the data should be edited. For instance, the Medicare program has a large range in the number of edits for medical necessity across the intermediaries. In addition, some states (e.g., California) require specific data definitions or editing for consistency across organizations. How will these issues be resolved? Whose rules should apply?

Recommendation: **The submission of encounter-level data should be exempted from this requirement until the bugs can be worked out of the information system exchanges and protocols at the provider, health plan, fiscal intermediary, state data reporting, and HCFA levels. HCFA should ensure that providers are not held accountable for errors they did not make or errors that result from following the plan's instructions. Audits by HCFA should be minimal and permit flexibility in practices across plans. Hospitals should not have to bear the costs of audit-related medical record review for plans.**

Calculation of M+C Capitation Payments

There are at least two central issues related to the calculation of capitated rates. The first is the continued failure to implement the blending of national and county utilization rates as specified in the BBA, and HCFA's request for comments on its plan to seek statutory change on blending of the capitated rates so that it fully accomplishes budget neutrality. The second relates to the implementation of more sophisticated risk adjustment of the rates.

Blending. The BBA requires that plans be paid the greater of a blended national/county rate, the minimum floor rate, or the minimum 2 percent update rate. For the first two years (1998 and 1999), the blended rate has been unavailable because it is only that rate which is adjusted to accomplish budget neutrality. In fact, even with payment limited to the greater of the floor or the 2 percent update in 1998 and 1999, HCFA was unable to fully accomplish budget neutrality. The preamble to the rule indicates that HCFA is considering seeking a statutory change to enable full compliance with budget neutrality. The AHA is concerned that HCFA may be moving in the wrong direction—that is, further reductions to enable full compliance with budget neutrality, rather than seeking funding to implement the blend. Implementation of blended national/county rates is critical to reduce the degree of variation in rates across counties and provide for more equitable beneficiary access to additional benefits as an incentive to select a M+C option.

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Recommendation: **The blend transition should be reinstated by funding its effect—that is, HCFA should support legislation to fund the blend rather than adjusting the blended rates downward to achieve budget neutrality. To that end, AHA-supported legislation has been introduced in the House (H.R. 4492) and the Senate (S.2227).**

Risk adjustment. The BBA requires that HCFA make risk-adjusted payments to plans beginning in the year 2000. These payments incorporate information on diagnoses, replacing the pure demographic model (e.g., age, sex, and institutional status). We are concerned about implementing the adjustment without an adequate database and without resolving a host of operating issues. It is especially important that HCFA have reasonably reliable estimated rates when performing ACR calculations. Significant differences between estimated rates (on which the ACR, benefit package, and premium are based) and actual payment rates could cause serious financial problems. At the same time, risk adjustment should be implemented. AHA is developing its response to the Sept. 8 *Federal Register* notice containing HCFA's methodology for the adjustments. We will be happy to share them with the committee when they are completed next week.

M+C Plan Standards for Prompt Payment of Providers

Hospitals and health systems are increasingly concerned about the failure of managed care plans to reimburse them in a timely manner. As a result, there has been a fair amount of activity at the state level, where managed care plans are regulated, to address issues related to prompt payment by plans. For example, the Florida Hospital Association earlier this year surveyed 20 hospitals. As of March 31, those hospitals reported that $166 million in claims for managed care patients were more than 30 days old. That figure represents 191,000 outstanding claims, half of which were more than 150 days past due.

Because Medicare is a federal program funded with federal dollars, we believe it is appropriate for the M+C program to establish standards for provider payment. On this issue there are two categories of health care providers: the provider who is under contract with a health plan—a contract provider; and the provider who is not under contract with a plan, but provides services (such as emergency services) to a plan's members—a non-contract provider.

The proposed prompt payment rule is taken largely from the previous Medicare risk-contractor rules, which required health plans to pay non-contract providers within 30 days for claims that are uncontested by the plan, and within 60 days for all others. This is essentially the same standard that applies under the traditional Medicare fee-for-service program, and that applies under the Medicaid program under all circumstances, whether in direct payment from the Medicaid program or to payment by a Medicaid managed care plan without regard to whether the provider is under contract with the plan.

The new rule establishes this standard for non-contracting providers, but not for contracting providers, where it simply requires that the parties define prompt payment in their contract. Increasingly, health plan contracting practices (buttressed by the constraints of regulatory review of provider contracts) often do not provide for the negotiation of terms other than rates of payment. In the absence of state prompt payment standards, providers are likely to be forced to accept a unilateral plan decision. This is especially the case because plans are under pressure to re-execute their provider contracts prior to the January 1, 1999 start of the M+C program, and because the detailed provider contracting guidelines are not expected from HCFA until some time later this month. Even if a plan is willing, there may not be sufficient time to negotiate mutually acceptable prompt payment time limits.

Recommendation: **HCFA should incorporate the same 30/60-day standard for contract providers as it has done for non-contract providers, unless a shorter standard is required by state law. This would ensure that a basic standard is included that is consistent with the rules governing prompt payment under Medicare and Medicaid in all contexts. Consistency in these requirements should mean greater consistency in claims processing.**

CONCLUSION

Mr. Chairman, AHA and its members are focusing significant resources on moving health care delivery to a more efficient and effective integrated model: provider-based health plans. Powerful market, regulatory, and demographic forces buttress our view that these plans are needed. But, regulation must allow our members to do the job right—to reach their full potential for beneficiaries, providers, and the government as well. This requires that HCFA rethink its traditional approach to regulation so that its rules reflect the lessons of the marketplace. As we attempt

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to build the health care system of the future, none of us can afford to be mired in the regulatory thinking of the past.

Medicare has been an outstanding success in bringing health care security to the elderly. In a nation where eroding access to health care coverage in the working population is already contributing to a steady rise in the number of uninsured, we must work to ensure that our nation keeps the Medicare promise. We look forward to working with you and with HCFA to ensure that Medicare+Choice plans can become significant contributors to a fiscally healthy Medicare program.

STATE OF OHIO
OFFICE OF THE GOVERNOR
October 2, 1998

The Honorable MICHAEL BILIRAKIS, *Chairman*
House Commerce Subcommittee on Health and Environment
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

DEAR CHAIRMAN BILIRAKIS: It is certainly appropriate and timely that your committee take the opportunity of the one year anniversary of the Medicare+Choice program in order to examine the program's ability in giving seniors meaningful options in exploring managed care options for Medicare.

As many of you are aware, a number of health plans throughout the United States have withdrawn their Medicare managed care products from certain areas of states. Here in Ohio,. Anthem Blue Cross and Blue Shield of Ohio announced the withdrawal of it's Anthem Senior Advantage HMO from all or parts of 22 counties, affecting some 20,000 Ohio Seniors in these primarily rural counties. In siting the rationale for pulling out of these areas, Anthem contended that the unequal reimbursement rates between the various counties, in addition to a de facto 2% rate increase over the next five years as the primary cause for their inability to keep their products in these counties (see attachment) Fortunately, Anthem has decided and HCFA has approved Anthem to return to 6 of the counties where no other Medicare managed care product exists. Although a new premium will be charged to consumers, I believe a more expensive option is better than no option at all.

Just today, I learned that United Health Care would be removing its product from 6 Ohio counties, affecting 10,000 Ohio Seniors. Here, again, the provisions of the Medicare+Choice provisions contained in the Balanced Budget Act were sited as the primary cause of the withdrawal.

While I applaud the intent of the Medicare+Choice program to offer a wider array of options in the private market place, I am concerned that implementation of the program may be having the opposite outcome—that plans, which were actuarially sound prior to the program, may now not be, thus undermining competition and options for seniors.

Most importantly, we have thousands of seniors here in Ohio and around the country who must endure the confusion and stress of having their HMO product terminated.

I urge the committee to take a hard look at the Medicare+Choice program so that seniors can explore true options in the private market place while maintaining at least some sense of security that their plan will remain intact.

Sincerely,

GEORGE V. VOINOVICH
Governor

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